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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

SHADY GROVE ORTHOPEDIC ASSOCIATES, P.A. on behalf of itself and all others similarly situated, Plaintiffs, vs. ALLSTATE INSURANCE COMPANY, Defendant.	**ECF CASE** CV 06 1842 (NG)(JO) **DECLARATION OF GIL LEIB IN SUPPORT OF DEFENDANT'S OPPOSITION TO MOTION FOR CLASS CERTIFICATION**

I, Gil Leib, being duly sworn, declare pursuant to 28 U.S.C. § 1746 that:

1. I am a Front Line Process Expert for defendant Allstate Insurance Company ("Allstate") in the above-captioned action. This Declaration is submitted in support of Allstate's Opposition to Shady Grove's Motion for Class Certification Pursuant to Fed. R. Civ. P. 23. I make this Declaration under penalty of perjury. This Declaration is based on my personal knowledge and/or a review of the documents produced in discovery in this litigation.

2. I have been working for Allstate since January 1986. In my current position as Front Line Process Expert ("FPE"), my duties and responsibilities include oversight of the process of a market claim office ("MCO"), which is Allstate's terminology for a claims office.

In New York State, Allstate currently has 3 MCOs that handle personal injury protection ("PIP") claims. The Islandia MCO, where I am based, handles exclusively PIP claims.

MEDICAL BILL REVIEW PROCESS

3. Whether statutory penalty interest is owed pursuant to Regulation 68 is governed by a multitude of factors and depends on the adjuster's subjective decision-making processes as well as the response time of the medical providers and insureds. To assist this Court in understanding the factors involved in determining if or when penalty interest is due and owing, I am providing the following summary of events from the time an insured gets into a car accident requiring medical attention to the payment of the medical bill by the insurer. This summary will address the timing of the events in order to explain that the 30-day clock can be tolled or extended depending on the circumstances of the party's injuries and/or the medical provider's treatment. Such summary will discuss the subjective decision-making processes and individualized analyses that Allstate adjusters must undertake in terms of the timing of the PIP payments and whether or not statutory penalty interest is owed.

4. As an initial matter, contrary to the allegations of the Complaint, which I have reviewed, Allstate has no policy, practice, or pattern of paying bills in an untimely manner. Allstate does not make false claims for the purpose of avoiding the payment of penalty interest. On the contrary, Allstate's policy is to pay medical bills in a timely manner so that statutory penalty interest does not have to be paid. Nor does Allstate routinely and/or knowingly fail to pay penalty interest if it is owed. Allstate does pay penalty interest, if warranted. To the extent a bill is paid late without statutory penalty interest (if that interest exceeds $5.00), such non-payment resulted from an isolated mistake, based on the high volume of bills that are analyzed at any given time period. On a daily basis, Allstate receives approximately 3,000 PIP medical bills

for review in New York State. With such a high volume of medical bills that Allstate must handle, some bills may be lost in the United States Postal system through no fault of Allstate, and errors will inevitably and occasionally be made by one of Allstate's claims adjusters. At any particular time, Allstate employs more than fifty (50) adjusters in New York to review PIP bills and claims. These adjusters undergo extensive training to ensure that the bills are handled in a timely and proper manner.

Claims/Bill Handling Process

5. When an insured is involved in a car accident, he or she will first notify Allstate, usually by telephone. After obtaining the basic information (including asking whether the insured sustained any injuries), the representative from Allstate will then open up a claim file and assign a claim number. This notice must provide details sufficient to identify the eligible injured party or "EIP," along with reasonably obtainable information regarding the time, place, and circumstances of the car accident. Within five (5) business days after notice is received, the insurer shall forward to the EIP the prescribed "Application for Motor Vehicle No-Fault Benefits." 11 NYCRR § 65-3.4(b). Written notice of the accident, which can be effectuated by the return of an NF-2 form, must be received by Allstate within thirty (30) days from the time of the accident.

6. If the collision is not serious, the insured may not seek medical treatment. If the EIP does require medical treatment as a result of the accident, that EIP would likely assign the claim to the medical provider who would send the bill(s) for treatment directly to the insurer. The medical provider, as the assignee of the injured party, cannot recover no-fault benefits if the notice of the accident is not timely submitted by the insured within such 30-day period.

7. The medical provider would then send the bill, along with the appropriate medical forms and other NF ("no-fault") forms described below, to the appropriate Allstate MCO which handles PIP claims. Once received by the MCO, the bill is date-stamped. All medical bills pre-2006 were then sent to the National Claims Service Center ("NCSC") for input into the computer system. NCSC reviews each document received for the indicative data that is needed to properly input the bill. Allstate needs to verify the injured person and the claim number that was assigned when the accident was first reported by the EIP. If any of the information is not correct, NCSC searches the Allstate claim system for a proper claim. If any additional information is needed, Allstate may call the provider or request additional information needed to match this bill to a claim. If this information cannot be obtained, or if a match is not found, the bill would be returned to the office that sent it to NCSC. The medical bills that have a valid claim number and injured party are then manually input in the bill analysis tool called "Mitchell Decision Point" ("MDP"), which is a software product to assist the adjusters in processing the medical bills and claims. The bills are immediately available after input to the adjuster for handling.

8. The adjuster must review the claim to determine a number of threshold issues:

(i) Whether the relevant policy of insurance was in effect at the time of the alleged accident;

(ii) Whether the individual was a "covered person" under the No Fault Statute;

(iii) Whether the individual was a "covered person" under the policy of insurance in effect;

(iv) Whether the claim was properly for No Fault Benefits resulting from the car accident (as opposed to a condition that was not caused by the accident, *e.g.*, sports injury or pregnancy);

(v) Whether any exclusions of coverage under the relevant policy of insurance are applicable;

(vi) Whether the coverage under the relevant policy of insurance had been exhausted;

(vi) Whether the party who submitted the bill for medical services did so pursuant to a valid assignment of benefits; and

(vii) Whether any fraud occurred.

9. Within ten (10) business days after the receipt of the completed NF-2 from the EIP, the insurer must forward a verification form for health care or hospital treatment to the EIP or the assignee, *i.e.*, the medical provider. This proof of claim must be submitted within forty-five (45) days from the date of service ("DOS"), meaning the date that the medical treatment was rendered. Such proof of claim is typically submitted by means of a "Verification of Treatment by Attending Physician or Other Provider of Health Services" (N.Y.S. Form NF-3), by means of a "Verification of Hospital Treatment" (N.Y.S. Form NF-4), or by means of a Hospital Facility Form" (N.Y.S. Form NF-5). The NF-3 and NF-4 forms also contain an assignment of no-fault benefits option that may be executed by the EIP.

10. These NF forms usually accompany a medical bill for the treatment of the EIP. The adjuster reviews bills assigned to him or her on a daily basis and usually prioritizes the review by the age of the bill. The bills are sorted by the "received date" so as to ensure regulatory compliance. The adjuster must then review all bills for the following:

a. Diagnosis

b. Date billed

c. Date received

d. Code billed

e. Modifiers billed

f. Causality

g. System edits

11. Once the adjuster receives all forms, medical documentation, verifications, and reports required to complete the proof of claim, the adjuster generally has thirty (30) days to decide if a bill is to be paid in full or in part, denied, or requires additional documentation or verification. If the bill is paid in part or in full, the adjuster will submit it for processing with the check and Explanation of Benefits ("EOB"). If the amount paid is less than the amount billed, the adjuster needs to review the system edit to make another subjective determination to ascertain whether the lower payment amount is correct or whether an adjustment is needed. The adjuster may need to review the Workers Compensation Fee Schedule ground rules to assist in the proper determination. Once the correct amount owed is determined, additional wording must be added to the EOB if necessary.

12. The initial 30-day period by which the adjuster must pay or deny the bill can be extended for a number of reasons. Within fifteen (15) business days after the receipt of the verification forms (NF-3, NF-4, or NF-5), the insurer may seek "additional verification" or further proof of claim from the EIP or his or her medical provider. 11 NYCRR § 65-3.5(b). Questions of causality can be addressed through several medical management tools, including Independent Medical Exams ("IME"), Peer Reviews, Record Reviews, and Radiology Reviews. If, for example, the insurer requests an IME of the EIP, the IME must be held within thirty (30) calendar days from the receipt of the initial verification forms (11 NYCRR § 65-3.5(d)). However, the IME is often delayed due to the unavailability of the EIP or re-scheduling by the EIP. The insurer can also request an examination under oath ("EUO"), which is conducted like a deposition. The request for an EUO "must be based upon the application of objective standards so that there is specific objective justification supporting the use of such examination." 11 NYCRR § 65-3.5(e). Again, the EUO is often delayed due to the unavailability of the EIP or re-

scheduling by the EIP. These delays extend the period of time by which Allstate has to pay or deny the claim.

13. If the requested additional verification (*e.g.*, EUO, other medical documentation, and certain IMEs for medical necessity such as dental and psychological treatments) has not been supplied to the insurer within thirty (30) calendar days after the original request, the insurer shall, within ten (10) calendar days, follow-up with the recalcitrant party "either by telephone call, properly documented in the file, or by mail." 11 NYCRR § 65-3.6(b). If the EIP fails to appear for the requested IME or EUO, the insurer has the right to deny all claims retroactively to the date of the loss, regardless of whether the denials were timely issued. Similarly, if the insurer does not receive the verification after its follow-up request is sent, the insurer's time to pay or deny the claim is tolled pending the submission of the requested information. A claim need not be paid or denied until all demanded verification is provided. Again, failure to provide the requested additional verification extends the period of time by which Allstate has to pay or deny the claim.

14. Once the medical provider or EIP provides the requested additional verification, the adjuster then reviews the submitted reports, information, transcripts, or test results, again making the individualized determination as to whether the treatment is medically necessary and/or whether the injury was causally related to the automobile accident.

15. Prior to payment in full or in part, the age of the bill needs to be reviewed to determine if penalty interest is owed. Pursuant to 11 NYCRR § 65-3.9(a), "[a]ll overdue mandatory and additional personal injury protection ["PIP"] benefits due an applicant or assignee shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month. This regulation continues, "When a payment is made on an overdue claim, any

interest calculated to be due in an amount exceeding $5 shall be paid to the applicant or the applicant's assignee without demand therefor." If penalty interest is owed, the proper field in the MDP program must be completed. If the amount of interest is less than $5.00, the interest payment does not have to be added to the payment amount. If the penalty interest is calculated to be more than $5.00, that interest amount will be added to the total payment amount.

16. I have attached as Exhibit "1" a document which reflects that the $5.00 threshold has been a part of 11 NYCRR § 65-3.9(a) as early as 1985. In my 13 years of experience with no-fault, I have communicated with certain medical providers who have indicated that they are aware of this $5.00 threshold. As a result of this provision, I am aware of no instance where a medical provider in New York challenged the $5.00 threshold or even made any demand for penalty interest in the amount less than $5.00.

17. If the adjuster decides to deny the claim, he or she must use the prescribed "Denial of Claim Form" (NF-10), which provides a detailed explanation for the denial. The adjuster may determine, based on the individualized facts at issue, that a claimed procedure was not medically necessary within a timely denial pursuant to the 30-day rule. The adjuster may also deny a claim based on the failure of the EIP or medical provider to submit a bill within 45 days from the date of service. Other defenses are available, such as lack of coverage or fraud.

18. Even if the claim is denied within or beyond the initial 30-day period, statutory interest is tolled under certain circumstances. Specifically, the tolling provision in 11 NYCRR § 65-3.9(c) applies where a claimant fails to commence a lawsuit or request arbitration within 30 days after the receipt of a denial of claim. Interest is tolled from the date of the denial until the date when the claimant commences a lawsuit or requests arbitration until arbitration or a lawsuit

is filed. This provision applies regardless of whether the denial of claim was timely or untimely issued.

GALVEZ CLAIM FILE AND SHADY GROVE BILLS

19. A true and accurate copy of Galvez's claim file with EOBs is attached as Exhibit "2". I am familiar with this clam file and the medical bills contained in the file. As this Court can see, the accident in which Galvez was involved generated approximately 18 bills from medical providers, including Plaintiff Shady Grove Orthopaedics, Shady Grove Radiology, Shady Grove Adventist, and Montgomery Emergency Physicians. Certain of these bills were submitted by Sandra F. Birnbaum, a physical therapist who appears to be associated with Plaintiff Shady Grove Orthopaedics. A number of bills are duplicate for the same services and treatment, and thus were denied by Allstate. The following describes the two bills which Shady Grove alleged that Allstate paid late without penalty interest.

June 15th Date of Service

20. One of the late bills in issue involved a date of service of 6/15/05, but was not received by Allstate until 10/31/05. This bill was denied on a timely basis (within 30 days) on the grounds that the medical provider submitted the bill more than forty-five (45) days from the date of service in contravention of Regulation 68 (Mandatory Policy Endorsement) and the insured's policy.

21. Allstate has no record of receiving this bill any earlier than 10/31/05.

June 29th Date of Service

22. The other bill in issue pertained to services provided by Sandra Birnbaum for physical therapy. Ms. Birnbaum submitted three bills at the same time. These bills sought payments for services dated 6/22/05, 6/27/05, and 6/29/05. All three bills were date stamped

received on 7/22/05. (*See* ALLSTATE (SG) 073723-073733). Two of the three bills were paid on a timely basis on 8/15/05. The third bill with DOS 6/29/05 was not paid on a timely basis. This delayed payment appears to be an oversight because multiple bills were included in one envelope. This bill certainly does not fit within the allegations that Allstate "routinely ignores" payment of interest or that Allstate "wrongly and knowingly" withheld statutory interest.

23. Ms. Galvez's claim file also includes a number of bills from Shady Grove Radiology and Montgomery Emergency Services which were denied because the medical services provided did not relate to the car accident but to her pregnancy. Those bills were submitted to Allstate in September and October of 2005.

REQUESTS FOR ADMISSIONS

24. The individualized analysis to determine whether penalty interest is due or owed is aptly and succinctly demonstrated by Shady Grove's Requests for Admissions and Allstate's responses to those requests. During the course of discovery, Shady Grove submitted three sets of Requests for Admissions ("RFAs"). In sum, Shady Grove's RFAs attached a number of EOBs and asked Allstate to admit that (i) each EOB reflects an instance in which PIP benefits became overdue; and (ii) as of the date of these requests, Allstate did not pay statutory interest with respect to such late payments. On their face, the "Bill Received Date" and the "payment date" (*i.e.*, date of the EOB) suggests that the payment was made in excess of thirty (30) days. Upon further review of the specific bill and the claim file, a different conclusion is reached, namely that penalty interest was not due or owed. At a minimum, a dispute existed with respect to the payment or denial decision and any penalty interest that was owed. The bottom line is that Shady Grove's allegations that Allstate routinely fails to pay penalty interest is not corroborated by Allstate's RFA responses. Penalty interest was owed only in very few, isolated instances.

First Set

25. On or about August 29, 2011, Shady Grove served Allstate with Plaintiff's First Set of Request for Admissions ("1st RFAs"). A copy of Allstate's responses to the 1st RFAs is annexed as Exhibit "5" to the accompanying Declaration of Andrew T. Hahn, Esq. (the "Hahn Declaration"). I have reviewed Shady Grove's 1st RFAs as well as Allstate's responses, and I can make the following observations. In sum, Shady Grove's 1st RFAs attached fifty-two (52) EOBs. As shown on the summary chart entitled, "Specific Responses to Request for Admissions" attached to Allstate's responses, out of the 52 EOBs, forty (40) of them did not require the payment of penalty interest pursuant to 11 NYCRR 65-3.9(a) because the amount of interest owed was less than $5.00.

26. The remaining twelve (12) EOBs involved the adjuster making subjective decisions and individualized analyses to determine whether additional verification or information was necessary. Such additional requests extended the period of time by which Allstate had to pay or deny. For example, with respect to Claim No. 11259644864 (Exhibit F of 1st RFAs), Allstate timely requested an IME, but the EIP failed to appear on the scheduled date, and re-scheduled the examination multiple times. Eventually, the IME was conducted, and Allstate partially paid the claim based on the IME on a timely basis such that no penalty interest was owed.

27. In other situations, Allstate made duplicate or overpayments, which would have covered any interest payment owed, and could provide a basis for a counterclaim against the medical provider to recover any excess. For example, Claim No. 2125389532(b) at Exhibit A of 1st RFAs is an example where Allstate paid the medical provider twice for the same service. In

another instance, Allstate timely paid the bill (Claim No. 1125963510 at Exhibit G of 1st RFAs), but the check was lost, and had to be re-issued.

Second Set

28. On or about November 17, 2011, Shady Grove served Allstate with Plaintiff's Second Set of Request for Admissions ("2nd RFAs"). A copy of Allstate's responses to the 2nd RFAs is annexed as Exhibit "6" to the Hahn Declaration. Shady Grove's 2nd RFAs attached twenty-six (26) EOBs. As shown in the summary chart entitled, "Specific Responses to the Second Request for Admissions" attached to Allstate's responses, out of the 26 EOBs, twenty-two (22) of them did not require the payment of penalty interest because the amount of interest owed was less than $5.00.

29. The remaining four (4) EOBs required individualized analyses as to the reason for the "late" payment, and, if so, whether any penalty interest was owed. Again, individualized analyses relating to those remaining four (4) EOBs show that no penalty interest was generally owed. One bill (Claim No. 2125793030(a) at Exhibit C of 2nd RFAs) involved an IME which had to be re-scheduled because of the EIP's unavailability, and another bill (Claim No. 2465197833(a) at Exhibit D of 2nd RFAs) involved another double payment situation.

Third Set

30. On or about February 2, 2012, Shady Grove served Allstate with Plaintiff's Third Set of Request for Admissions ("3rd RFAs"). A copy of Allstate's responses to the 3rd RFAs is annexed as Exhibit "7" to the Hahn Declaration. Shady Grove's 3rd RFAs attached twenty-two (22) EOBs, and out of those 22 EOBs, eleven (11) of them did not require the payment of penalty interest because the amount of interest owed was less than $5.00. Of the eleven remaining EOBs, six (6) claims were denied, meaning that Allstate disputed the claim, and

therefore refused to pay it. Of the remaining five claims, Allstate adjusters analyzed the bills and determined that no penalty interest was due or owed. For example, one payment of a claim (Claim No. 1125964203 at Exhibit B of 3rd RFAs) involved yet another duplicate payment of claim that was already paid in a timely manner, and another claim (Claim No. 4144200988 at Exhibit I of 3rd RFAs) was paid timely after an EUO. Another claim (Claim No. 8140363220 at Exhibit K of 3rd RFAs) involved a delayed payment due to the medical provider's tardy submission of medical records for a peer review. When the medical provider finally provided the requested records, payment of the claim was timely made.

31. In sum, Shady Grove's "one and done" methodology does not determine in any objective manner whether penalty interest was owed. Further individualized analyses of each bill and each claim file must be undertaken to determine whether penalty interest was owed. Such analyses were conducted in order to respond to Shady Grove's RFAs and resulted in the conclusion that penalty interest generally was not owed.

MARKET CONDUCT EXAMINATION

32. During the 2006 and 2007 time frame, I was asked by my superiors to assist in a "market conduct examination" by the New York State Insurance Department ("NYSID"), which was merged recently into the Department of Finance. During a market conduct examination, or "MCE," NYSID reviews the insurer's business practices from a regulatory compliance perspective such as underwriting practices and claims handling practices. Specifically, I assisted in that part of the MCE related to PIP claim handling practices. It is my understanding that the regulators from NYSID requested a list of claim files for a particular time period, and from that list, the regulators highlighted the claim files which they wanted to review. The regulators

selected 50 to 100 claim files, and my responsibility was to locate and retrieve those files and any ancillary information.

33. A team from NYSID consisting of about four or five auditors came to our offices to review these PIP claim files. Like the review of the claim files to respond to Shady Grove's RFAs during the discovery period, the auditors examined each bill in each PIP claim file to determine whether any regulatory violation occurred, including the payment of penalty interest. During the MCE, NYSID would engage in a dialogue with Allstate with respect to certain claim handling practices and would point to perceived violations of the insurance regulations. With regard to these perceived violations, Allstate would have an opportunity to respond and state whether or not Allstate agreed with the finding of a violation. Allstate would challenge the violation by explaining its position. Further dialogue between supervisors from Allstate and NYSID would ensue. NYSID would determine whether a violation "stayed" or was to be "removed." Allstate would have several opportunities to engage in discussion with respect to the finding of any purported violations.

34. No findings have resulted from the MCE, and NYSID assessed no fines or penalties on Allstate for any violation.

Executed on: New York, New York
May 30, 2012

GIL LEIB

DECLARATION OF GIL LEIB
EXHIBIT 1

MARIO M. CUOMO
GOVERNOR
JAMES P. CORCORAN
SUPERINTENDENT OF INSURANCE

STATE OF NEW YORK INSURANCE DEPARTMENT

INSURANCE NEWS

160 WEST BROADWAY, NY, NY 10013

CONTACT:
KEVIN FOLEY
DIRECTOR OF PUBLIC AFFAIRS
(212) 602-0428

ISSUED: 9/20/85

FOR IMMEDIATE RELEASE

NEW NO-FAULT REGULATION RELEASED

Superintendent of Insurance James P. Corcoran today announced promulgation of Amendment 19 to Regulation No. 68 (11NYCRR 65). Regulation 68 implements New York's motor vehicle no-fault law.

The Amendment will significantly improve claims handling by insurance companies and decrease no-fault arbitrations by requiring genuine attempts at adjustment of claims by attorneys prior to resorting to the arbitration process. In addition, the Amendment establishes a time limitation for presentation of medical bills to the insurer. Fees for attorneys and arbitration were also increased.

The revisions contained in Amendment 19 include:

1. The following revisions to the Mandatory Personal Injury Protection Endorsement:

a.) establishment for the first time of a time limitation for presentation of health service claims of the later of 180 days from the date of treatment or the date written notice of the claim is first submitted to the insurer or self-insurer, and

NEW YORK STATE (w/Attachment)
Copies to: T. Steele
P. Brodnax
F. Wasmer
S. King
G. Hultberg

/more

(7) Where the insurer has determined that a self-employed applicant's disability arose from the claimed accident, the insurer shall be deemed to have proof of claim for loss of earnings or substitute services, subject to receipt of medical proof of disability for the period claimed, when it has received a completed prescribed verification of self-employment income form (NYS N-F 7) and the proof requested thereon. The insurer shall determine therefrom the amount of loss of earnings benefits, if any, due the applicant. Notwithstanding the above, if an insurer requires verification in addition to the proof supplied, it may request such additional verification pursuant to paragraph (d)(2) of this section.

(8) A death benefit claim will be deemed to have been proven when the insurer receives a copy of the decedent's death certificate and proof that the personal representative of the decedent's estate was duly appointed in this State or any other jurisdiction.

(9) A failure to observe[the foregoing] any of the time frames specified in this section shall not prevent an insurer from requiring proper proof of claim.

(10) For the purposes of counting the 30 calendar days after proof of claim, wherein the claim becomes overdue pursuant to section [675] 5106 of the Insurance Law, with the exception of subdivision (e) of this section any deviation from the rules set out in this section shall reduce the 30 calendar days allowed.

Example: Where an insurer sends an application for motor vehicle no-fault benefits 15 business days after notice is received at the address of the insurer's proper claim processing office instead of five business days, the 30 calendar days permitted by paragraph (f)(1) of this section is reduced to 20 calendar days.

(g) Interest on overdue payments. (1) All overdue mandatory personal injury protection benefits due an applicant or assignee shall bear interest at a rate of two percent per month, compounded and calculated on a pro rata basis using a 30-day month. The aforementioned two percent per month interest shall also be payable on all overdue additional personal injury protection benefits due an applicant or assignee as a result of an accident occurring on or after January 1, 1982. When payment is made on an overdue claim, any interest calculated to be due in an amount exceeding five dollars shall be paid to the applicant or the applicant's assignee without demand therefor.

(2) The insurer shall not suggest that the interest due be waived.

(3) If an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations, interest shall not

MATTER IN BRACKETS DELETED; MATTER UNDERLINED IS NEW

DECLARATION OF GIL LEIB
EXHIBIT 2

PLEASE DO NOT STAPLE IN THIS AREA

2125843132

ALLSTATE
22600 GATEWAY CENTER DR
CLARKSBURG, MD 20871-2004

BALT MKK

XXX PICA APPROVED OMB-0938-0008 **HEALTH INSURANCE CLAIM FORM**

FOLD

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 212584313 2

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY | STATE: NY

8. PATIENT STATUS: Single X | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (INCLUDE AREA CODE)

ZIP CODE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES X | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 5/31/05
SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE
SIGNED ____

FOLD

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 5 30 05

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY: 5 30 05

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM ____ TO ____

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM ____ TO ____

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 847.0
2. 847.2
3. E812.0
4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	5 31 05		23	1	99283		1,2,3	190 00	1		X		
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 522043450 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 425439

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X | NO

28. TOTAL CHARGE: $ 19000

29. AMOUNT PAID: $

30. BALANCE DUE: $ 19000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
MARCELE HILLS PA
SIGNED 8/09/05

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE ADVENTIST HSP
9901 MEDICAL CENTER DR
ROCKVILLE MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 240 364 2515
MONTGOMERY EMERGENCY PHYS
PO BOX 17564
BALTIMORE MD 21297
PIN# | GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM CMS-1500 (U2)(12-90)
FORM OWCP-1500 FORM RRB-1500

US01-ALLS01- 425439 LBOWYER

00001

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073684

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424-32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed. Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSES(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as a name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

NOTICE: *Under penalty of perjury, I declare that I have read the foregoing, that the facts are true, to the best of my knowledge and belief, and that the treatment and services rendered were reasonable and necessary with respect to the bodily injury sustained.*

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073685

PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE
22600 GATEWAY CENTER DR
CLARKSBURG, MD 20871-2004

1452

XXX PICA APPROVED OMB-0938-0008 **HEALTH INSURANCE CLAIM FORM**

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)	
						X	2125843132		

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
	M / F X	SAME	
6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
Self X Spouse Child Other		SAME	
CITY / STATE	8. PATIENT STATUS	CITY / STATE	
/ NY	Single X Married Other		
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO	a. INSURED'S DATE OF BIRTH / SEX M F X	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? X YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME	
		ALLSTATE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes,* return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 6/07/05
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE
SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 5 30 05	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY: 5 30 05	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. 847.0 3. E929.0		23. PRIOR AUTHORIZATION NUMBER
2. 922.31 4.		

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
6 07 05		23	1	99283		1,2,3	190 00	1		X		

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
522043450 / X	425439	X YES NO	$ 19000	$	$ 19000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 240 364 2515
BRICE TAYLOR PA	SHADY GROVE ADVENTIST HSP	MONTGOMERY EMERGENCY PHYS
SIGNED 8/09/05	9901 MEDICAL CENTER DR	PO BOX 17564
	ROCKVILLE MD 20850	BALTIMORE MD 21297
		PIN# / GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM CMS-1500 (U2)(12-90) FORM OWCP-1500 FORM RRB-1500

801-ALLS01- 425439 LBOWYER 00002

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073686

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ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Service and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice fo representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies i connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-part liability, coordination of benefits; and civil and criminal litigation related to the operation of CHAMPUS.

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I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

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NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

NOTICE: *Under penalty of perjury, I declare that I have read the foregoing, that the facts are true, to the best of my knowledge and belief, and that the treatment and services rendered were reasonable and necessary with respect to the bodily injury sustained.*

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073687

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073688

-L1751

ALLSTATE INSURANCE COMPANY
MARKET CLAIM OFFICE
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788-2940

MONTGOMERY EMERGENCY PHYS
PO BOX 17564
BALTIMORE MD 21297-1564

ALLSTATE INSURANCE COMPANY
NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment)

Dawn M. Maciaszek
Desk: 2AW
866-371-8905

Injured Party:

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
09/02/05			May 30, 2005	212584313Z

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER TREATMENT DATE, DEPENDING UPON POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. Patient's Name and Addre

2. Age 30 | 3. Sex F | 4. Occupation (if known)

5. Diagnosis and Concurrent Conditions
Sprain / Strain 847.0

6. When did symptoms first appear? Date: 5/31/05

7. When did patient first consult you for this condition? Date: 5/31/05

8. Has patient ever had same or similar condition? Yes ☑ No ☐ If "Yes", state when and describe: 6/7/05 Strain

9. Is condition solely a result of this automobile accident? Yes ☑ No ☐ If "No", explain.

10. Is condition due to injury arising out of patient's employment? Yes ☐ No ☐ unknown

11. Will injury result in significant disfigurement or permanent disability? Yes ☐ No ☑ Not determinable at this time ☐
If "Yes", describe:

12. Patient was disabled (unable to work) From:_____ Through:_____

13. If still disabled the patient should be able to return to work on:_____(date)

14. Will the patient require rehabilitation and/or occupational therapy as a result of the injuries sustained in this accident?
Yes ☐ No ☐ If "Yes", describe your recommendation below: unknown

CONTINUE ON PAGE 2

050902002590603R

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073690

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICES

15. Report of services rendered - Attach additional sheets if necessary

Date of Service	Place of Service Including Zip Code	Description of Treatment or Health Service Rendered	Fee Schedule Treatment Code	Charges
5/31/05 & 6/1/05	9901 Medical Ctr Dr Rockville, MD 20850	Emergency Evaluation Moderate	99283 99283	$190.00 $190.00
			Total Charges to Date $	380.00

16. If Treating provider is different than billing provider complete the following:

Treating Provider's Name	Title	License or Certification Number	Business Relationship Check Application Box		
			Employee	Independent	Other(Specify)

17. If the Provider of Service is a Professional Service Corporation or doing business under an assumed name (DBA), list the owner and professional licensing credentials of all owners (provide an additional attachment if necessary).

18. Is patient still under your care for this condition? Yes ☐ No ☑

19. Estimated duration of future treatment

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer **(Authorization to Pay Benefits)** so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____ **(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW

Print Name _____ Signed _____

PATIENT PATIENT DATE

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider **(Assignment of Benefits)**. If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 of the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ **(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE).**

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

Print Name _____ Signed _____

PATIENT (Assignor) PATIENT DATE

Print Name _____ Signed _____

(PROVIDER OF HEALTH CARE SERVICE - Assignee) (PROVIDER OF HEALTH CARE SERVICE) DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? Yes ☐ No ☐

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? Yes ☐ No ☐

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
9/30/05	Laura Bowyer (Authorized billing agent for MES)	52-2043750	Emergency Medicine

C7122NY-3 NYS FORM NF-3 (Rev 1/2004)

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ALLSTATE (SG) 073691

THIS ADDRESS INFORMATION MUST APPEAR IN RETURN ENVELOPE WINDOW.

ALLSTATE INSURANCE COMPANY
MARKET CLAIM OFFICE
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788-2940

PLEASE FOLD ON LINE

ALLSTATE INSURANCE COMPANY
MARKET CLAIM OFFICE
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788-2940

PLEASE FOLD ON LINE

ALLSTATE INSURANCE COMPANY
MARKET CLAIM OFFICE
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788-2940

050902002590603R

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☐ completed_____

17 **MVA** (5)

☒ Nursing Assessment Reviewed ☒ Vitals Reviewed ☐ Tetanus Immun. UTD

TIME SEEN: 12:00pm ROOM: M-6 __ EMS Arrival
PMD - Dr. Dr. Gupta
Referred by: ☒ Self ☐ PMD ☐ Dr.
HISTORIAN: patient __spouse __paramedics
__HX / __EXAM LIMITED BY:

HPI chief complaint: MVA Injury to: Neck / back
pain at: 0 1 2 3 4 5 6 7 8 9 10

occurred: __just PTA Yesterday
position in vehicle: driver passenger front back
context: 2 -car collision overturned vehicle
single-car accident (lost control / fell asleep / unknown cause)
Pt was struck by behind. No pain until the next am. Had neck/back pain/stiffness.

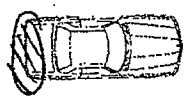
location of pain / injuries:
head face mouth
neck chest abdomen
back upper mid lower
radiating to (R / L) thigh / leg

-right-		-left-	
shldr	hip	shldr	hip
arm	thigh	arm	thigh
elbow	knee	elbow	knee
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	hand	foot

severity of pain:
mild
moderate to severe

associated symptoms:
__lost consciousness / dazed
duration:
remembers:
impact coming to hospital
__seizure

site of impact:
"P" = primary "S" = secondary



force low mod. high
direct glancing

restraints:
none lap / shoulder
doesn't recall
car seat
air bag deployed
thrown from vehicle
ambulated at scene
long extrication

ROS

SOCIAL HISTORY

PAST HX negative
NTDDM

Meds- __none / __see nurses note Advil, Oral Hypoglycemic
__herbal / alternative medicines
Allergies- NKDA __see nurses note

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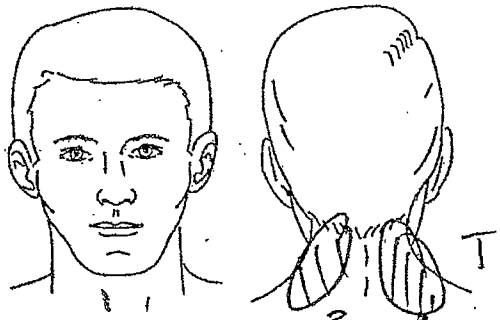
Shady Grove Adventist Hospital
EMERGENCY PHYSICIAN RECORD

PHYSICAL EXAM Alert __Lethargic __Anxious
Distress- NAD __mild __moderate __severe
Other- __c-collar (PTA / In ED) __back-board __IV __splint

HEAD
no evidence of trauma
__see diagram
__Battle's sign / Raccoon Eyes

NECK emerg
~~non-tender~~
~~painless ROM~~
trachea midline
see diagram
__vertebral point-tenderness
__muscle spasm / decreased ROM
__pain on movement of neck



EYES
PERRL
EOMI
__unequal pupils R- 3 mm L- 3 mm
__EOM entrapment / palsy
__subconjunctival hemorrhage

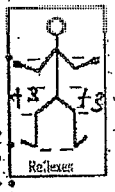
ENT
nml external inspection
no dental injury
__hemotympanum
__TM obscured by wax
__clotted nasal blood
__dental injury / malocclusion

RESP / CVS
chest non-tender
breath sounds nml
heart sounds nml
__see diagram (on reverse)
__decreased breath sounds
__wheezing / rales
__splinting / paradoxical movements

ABDOMEN
non-tender
no organomegaly
__see diagram (on reverse)
__tenderness / guarding / rebound
__mass / organomegaly

GENITAL / RECTAL

NEURO / PSYCH
oriented x3
mood & affect
CN'S nml as tested
sensation & motor nml
__confusion / disorientation
__EOM palsy / anisocoria
__facial asymmetry
__unsteady / ataxic gait
__sensory / motor deficit



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SKIN
- intact
- warm, dry

BACK
- no CVA tenderness
- no vertebral tenderness

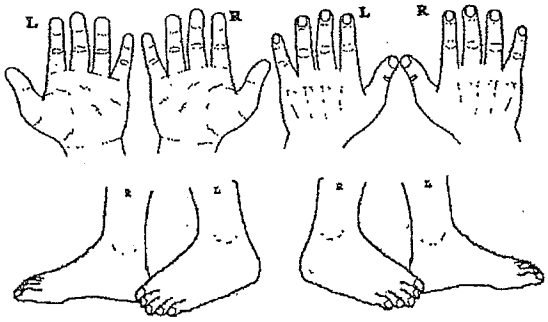
EXTREMITIES
- atraumatic
- pelvis stable
- hips non-tender
- no pedal edema
- nml ROM

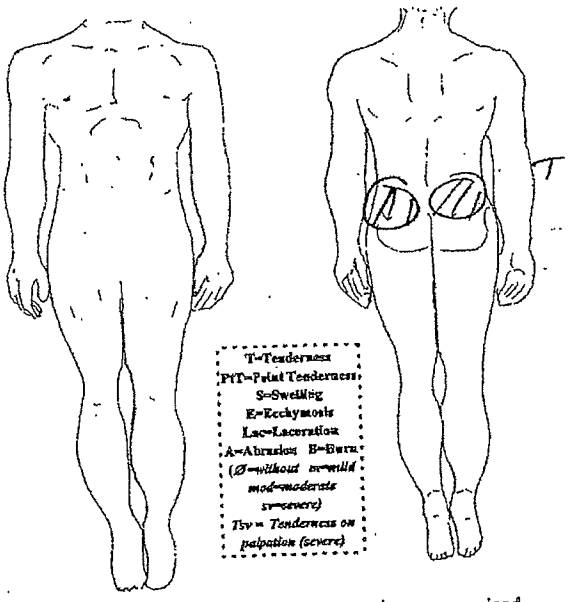
see diagram
crepitus / diaphoresis

see diagram
vertebral point-tenderness
CVA tenderness
muscle spasm / limited ROM

see diagram
bony point-tenderness
pain at / unable to bear weight
pulse deficit

Joint Exam:
limited ROM / ligaments laxity / joint effusion





XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/ radiologist

C-Spine D-Spine LS-Spine	
nml / NAD	reversal / straightening of cerv. lordosis
no fracture	DJD / spondylosis / spurring
nml alignment	
soft tissues nml	

CXR	
nml / NAD	rib fracture
no infiltrates	infiltrate / atelectasis
nml heart size	
nml mediastinum	

OTHER ☐ See separate report

Time ____ unchanged, improved re-examined
pain at

signed out to Dr.

CLINICAL IMPRESSION: MVA

contusion				sprain / strain	
head		wrist	R / L	neck dorsal lumbar	
face		hand	R / L	sacral	
chest		hip	R / L		
abdomen		thigh	R / L	concussion	
back		knee	R / L	with LOC w/o LOC	
shoulder	R / L	leg	R / L		
arm	R / L	ankle	R / L	laceration	
elbow	R / L	foot	R / L		
forearm	R / L				

DISPOSITION: ☐ home ☐ admitted ☐ transferred
CONDITION: ☐ unchanged ☐ improved ☐ stable

MD / DO:
PA:

PROCEDURES and PROGRESS:

Wound Description / Repair

length ____ cm location ____
superficial SQ muscle linear stellate irregular
clean contaminated moderately / heavily
distal NV neuro & vascular status intact no tendon injury
anesthesia local digital block
lidoc 1% 2% epi / bicarb marcaine .25% .5% LF
prep
Betadine / Hibiclens
irrigated / washed w/ saline
normal saline
explored
debrided / undermined
removed
foreign material removed
minimal moderate extensive
repair: Wound cleaned with wound cleanser / skin stapler
SKIN # 0 nylon / prolene / staples
SUBCU # 0 vicryl / chromic
A physician-assisted procedure may not exceed a maximum of ____ hours.

MVA - 17

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ALLSTATE (SG) 073695

67764

L01 APPROVED OMB NO. 0938-0279

SHADY GROVE ADVENTIST HOS
P.O. BOX 62153
BALTIMORE MD 21264 2153
301-315-3660

3 PATIENT CONTROL NO. 26306902

4 TYPE OF BILL 131

5 FED. TAX NO. 521532556

6 STATEMENT COVERS PERIOD FROM 060705 THROUGH 060705

7 COV D. 8 N-C D. 9 C-I D. 10 L-R D. 11 67764 (A)

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX F | 16 MS S | 17 ADMISSION DATE 060705 | 18 HR 09 | 19 TYPE | 20 SRC 7 | 21 D HR | 22 STAT 01 | 23 MEDICAL RECORD NO. 0861835

32 OCCURRENCE CODE 01 DATE 053005

33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

39 VALUE CODES CODE 45 AMOUNT 07 00 | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COV'D CHRGS	49
251	DRUGS/GENERIC		060705	1	006		
320	DX X-RAY	71020	060705	1	7759		
320	DX X-RAY	72040	060705	1	7759		
450	EMERG ROOM	99283	060705	1	11500		
730	EKG/ECG	93005	060705	1	3203		
001	TOTAL CHARGES				30227		

212584132108

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	ALLSTATE INSURANCE CO 05		Y	Y		30227	
B	SELF-PAY 08		Y	Y			
C							

57 DUE FROM PATIENT

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A		18		ALLSTATE (NY)	212584132
B		18			AUTO INS
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A		9	MBTY	BOHEMIA NY
B		1	MBTY	BOHEMIA NY
C				

67 PRIN. DIAG. CD. 92231 | 68 8470 | 76 ADM. DIAG. CD. 9598 | 77 E-CODE E8120 | 78

79 P.C. 9 | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A B C D E

82 ATTENDING PHYS. ID 58625 WENK, JONATHAN M MD

83 OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE X | 86 DATE 062805

UB-92 HCFA-1450 PAYER COPY

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Medical Account Management, Inc.
P.O. Box 10159
Towson, MD 21285
Phone: 410-828-0383 • Fax:410-828-8906

July 11, 2005

Allstate / 212584132
888 Veterans Memorial Highway
New York, NY 11788

RE: Shady Grove Adventist Hospital
Patient: [redacted]
Account #: 26306902
Date of Service: 6/7/05
Policy# /Claim#: 212584132
Total Amount: $302.27

Dear Sir/Madam:

This office has been requested by Shady Grove Adventist Hospital to submit the above referenced account, along with all the enclosed documentation in order to expedite processing of this account.

In the event you require further assistance in resolving this matter, please contact this office directly, preferably by written correspondence. If immediate assistance is required, contact this office at the number listed above. Thank you for your assistance and cooperation in this matter.

Medical Account Management Inc.
Billing Department

Additional Comments –
Please respond in writing to the address listed above.
Attn: F. George Lahourcade III – Senior MVA Specialist

Medical Account Management, Inc.
P.O. Box 10159
Towson, MD 21285
Mailer
012H162027666
$00.370
07/11/2005
Mailed From 21204
US POSTAGE

09/20/2005 13:54 3015902654 PAGE 02

APPROVED OMB-0938-0008

ALLSTATE
888 VETERANS HWY
SUITE 300
HAUPPAUGE, NY 11788

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CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 212584313ZAW

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE | SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): SAME

CITY | STATE: MD

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

Employed [ ] Full Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: MBTY

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/07/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: JONATHAN WENK MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: H65337

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V71.4
2. 959.09
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06072005	06072005	23	4	72020	26	1	50 50	1				
2 06072005	06072005	23	4	72050	26	2	82 50	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 52-1148069 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 500861835

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 133 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 133 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ALLYN N COHEN MD
SIGNED 09/20/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SHADY GROVE ADV HOSP
9901 MEDICAL CENTER DR,
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SHADY GROVE RADIOLOGICAL
PO BOX 17124
BALTIMORE, MD 21297

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

RECEIVED TIME SEP. 20. 1:49PM

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMP

PATIENT AND INSURED INFORMATION

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ALLSTATE (SG) 073701

Account Ledger

Shady Grove Orthopaedic Associates, P.A.
9715 Medical Center Drive
Suite 415
Rockville, MD 20850

Phone: (301) 340-9200 **Tax ID:** 521061922
Account: 151210P **SSN:**
DOB:

Responsible Party: Self
Insurance 1 (0015785120515) Allstate Insurance

Home Phone:
Work Phone:

Primary Provider: (9) Mark A. Peterson, M.D.
Referring Physician: (5161) MARK PETERSON

Balance of Transactions in Closed Controls

	Total	Current	1 to 30	31 to 60	61 to 90	91 to 120	121 to 150	Over 1
Bill	$1,233.00	$0.00	$487.00	$746.00	$0.00	$0.00	$0.00	$0
No Bill	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0

Type	Provider	Service Date	Code	#	Description		Charge	Payment	Adjustm
C	(9) Peterson, M.D.	06/15/2005	06/15/2005	99204	1	Office or other outpatient visit for th	$168.00		
C	(9) Peterson, M.D.	06/15/2005	06/15/2005	72100	1	Radiologic examination, spine, lum	$99.00		
Visit Entry Date: 06/20/2005		Visit Status: Bill				Visit Balance: $267.00	$267.00	$0.00	$(
C	(12) Birnbaum, P.T.	06/22/2005	06/22/2005	97001	1	Physical therapy evaluation	$135.00		
C	(12) Birnbaum, P.T.	06/22/2005	06/22/2005	97110	1	Therapeutic procedure, one or mor	$43.00		
C	(12) Birnbaum, P.T.	06/22/2005	06/22/2005	97140	1	Manual therapy techniques (eg, mc	$43.00		
Visit Entry Date: 06/22/2005		Visit Status: Bill				Visit Balance: $221.00	$221.00	$0.00	$(
C	(12) Birnbaum, P.T.	06/27/2005	06/27/2005	97110	1	Therapeutic procedure, one or mor	$43.00		
C	(12) Birnbaum, P.T.	06/27/2005	06/27/2005	97140	2	Manual therapy techniques (eg, mc	$86.00		
Visit Entry Date: 06/27/2005		Visit Status: Bill				Visit Balance: $129.00	$129.00	$0.00	$(
C	(12) Birnbaum, P.T.	06/29/2005	06/29/2005	97110	1	Therapeutic procedure, one or mor	$43.00		
C	(12) Birnbaum, P.T.	06/29/2005	06/29/2005	97140	2	Manual therapy techniques (eg, mc	$86.00		
Visit Entry Date: 06/29/2005		Visit Status: Bill				Visit Balance: $129.00	$129.00	$0.00	$(
C	(9) Peterson, M.D.	06/29/2005	06/29/2005	99213	1	Office or other outpatient visit for th	$100.00		
Visit Entry Date: 07/05/2005		Visit Status: Bill				Visit Balance: $100.00	$100.00	$0.00	$(
C	(12) Birnbaum, P.T.	07/06/2005	07/06/2005	97110	1	Therapeutic procedure, one or mor	$43.00		
C	(12) Birnbaum, P.T.	07/06/2005	07/06/2005	97140	2	Manual therapy techniques (eg, mc	$86.00		
Visit Entry Date: 07/06/2005		Visit Status: Bill				Visit Balance: $129.00	$129.00	$0.00	$(
C	(12) Birnbaum, P.T.	07/08/2005	07/08/2005	99080	1	Report Fee	$5.00		
P	(12) Birnbaum, P.T.	07/08/2005	07/08/2005	019	1	Cash Payment Office Thank You		($5.00)	
Visit Entry Date: 07/07/2005		Visit Status: Bill				Visit Balance: $0.00	$5.00	($5.00)	$(
C	(12) Birnbaum, P.T.	07/11/2005	07/11/2005	97110	1	Therapeutic procedure, one or mor	$43.00		
C	(12) Birnbaum, P.T.	07/11/2005	07/11/2005	97140	2	Manual therapy techniques (eg, mc	$86.00		
Visit Entry Date: 07/11/2005		Visit Status: Bill				Visit Balance: $129.00	$129.00	$0.00	$(
C	(12) Birnbaum, P.T.	07/13/2005	07/13/2005	97110	1	Therapeutic procedure, one or mor	$43.00		
C	(12) Birnbaum, P.T.	07/13/2005	07/13/2005	97140	2	Manual therapy techniques (eg, mc	$86.00		
Visit Entry Date: 07/13/2005		Visit Status: Bill				Visit Balance: $129.00	$129.00	$0.00	$(
Totals:									
Bill: $1,233.00		No-Bill: $0.00				Total: $1,233.00	$1,238.00	($5.00)	$(

C = Charge; I = Insurance Payment; P = Private Payment; A = Adjustment; F = Insurance Filing; M = Memo
Showing: Selected Visits from 06/15/2005 - 08/01/2005
• Indicates a preliminary (open) transaction that is subject to review.

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ALLSTATE (SG) 073702

09/20/2005 13:54 3015902654 PAGE 01

SHADY GROVE RADIOLOGICAL CONSULTANTS, P.A.
P.O. BOX 17124
BALTIMORE, MD 21297-1124

LHJ

FACSIMILE TRANSMITTAL COVER PAGE

TO: Allstate Dawn M
DATE: 9-20
COMPANY: Allstate

FAX: 631 435 7710

FROM: Paul
PHONE: 301 212 4260
FAX: 301-590-2654

PAGES 2 (incl. cover sheet)

Remarks:

eliminent sonic Golvez

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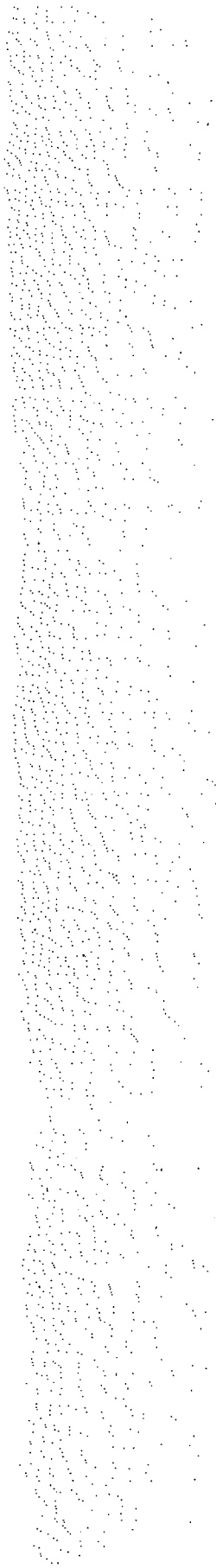
RECEIVED TIME SEP. 20. 1:49PM



PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

Type: Refile
User: bnolan

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0015785120515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE / SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE: MD

8. PATIENT STATUS: Single X Married Other
Employed X Full-Time Student Part-Time Student

CITY | STATE: MD

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 2125843108

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO X

a. INSURED'S DATE OF BIRTH / SEX: M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M F

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 05 30 2005

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. L847.0
2. L847.2
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 15 2005	06 15 2005	11	01	99204		12	168 00	1				
2 06 15 2005	06 15 2005	11	04	72100		12	99 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 521061922 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES NO X

28. TOTAL CHARGE: $ 267 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 267 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
MARK A. PETERSON, M.D.
SIGNED 10/25/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE-ROCKVILLE
9715 MEDICAL CTR DR.
SUITE 415
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO ASSOC
9715 MEDICAL CTR DR.
SUITE 415
ROCKVILLE, MD 20850 (301) 251-4143
PIN # GRP 521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CARRIER — CARRIER'S PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073705

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED B APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information ma be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to proce the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signatu authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group heal insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 4 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charg and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charg determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program b makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in thos items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure ar diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnishe incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPU regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervisi by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employe of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claim I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subje to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lur programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), ar 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the servic and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Fede agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessa to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosur are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 2 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishme of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupme claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be ma to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, clair adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil a criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discuss below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services render or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would del payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 380 3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of compu matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furni information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

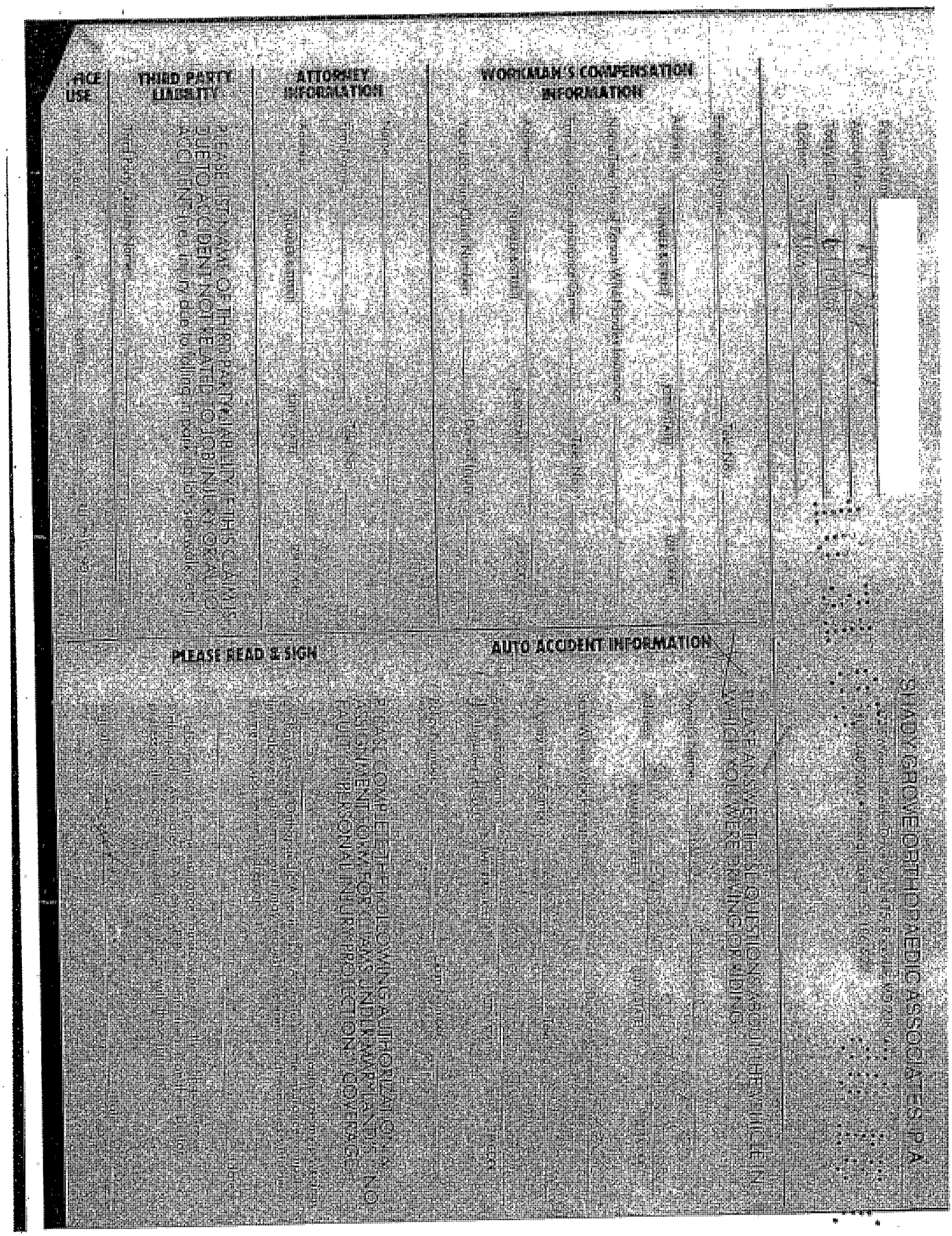
I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the excepti of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and we personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and Sta funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control numb The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the informati collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7 Security Boulevard, Baltimore, Maryland 21244-1850.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073706


ACE USE
THIRD PARTY LIABILITY
ATTORNEY INFORMATION
WORKMAN'S COMPENSATION INFORMATION
PLEASE READ & SIGN
AUTO ACCIDENT INFORMATION
SLIMOW GROVE ORTHOPAEDIC ASSOCIATES P.A.

SHADY GROVE
ORTHOPAEDIC ASSOCIATES, P.A.
ORTHOPAEDIC SURGERY
9715 MEDICAL CENTER DR., #415
ROCKVILLE, MD 20850

6/15/2005 MAP 151210P DOB:

PRESENT ILLNESS: comes in today. She is a 30-year-old female who was involved in a motor vehicle accident on 5/30/2005. She was rear-ended on the way home to New York in Delaware. She was ambulatory at the scene. She did not really hurt at the scene, but the next day was having discomfort in the neck, went to Shady Grove Hospital after her boyfriend picked her up. She was evaluated and released. She went back a week later because of continued pain and stiffness in her neck and back. She had x-rays taken of her cervical spine which were normal and she was released. She is still complaining of pain in the neck and the back. She has also complained of pain in the right knee, but this apparently happened prior to the accident. She twisted her foot and hurt her knee at that time.

PHYSICAL EXAM: On exam today, she complains of a lot of discomfort in the cervical region. There is pain in the trapezial region. It does not radiate down the arms. She has very limited motion with attempts at movement of her neck because of the pain. Examination of her back shows she has tenderness along the lower lumbar region. She has good motion. No paraspinal spasms. She is neurovascularly intact in both upper and lower extremities.

X-RAYS: X-ray report of the neck was normal. X-rays of her lumbar spine were taken which were normal.

ASSESSMENT: CERVICAL AND LUMBAR STRAIN.

PLAN: I have discussed with her the diagnosis and treatment. I am going to start her on a short course of therapy. I have given her some Vicodin for pain. I told her at this point that I do not think there is any reason she couldn't try working with this though it may be uncomfortable. I would like to see her back in 2 weeks to see how she is doing. /vmq

Mark A. Peterson, M.D.

cc: PIP

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA

9715 Medical Center Dr.
Suite 415
Rockville, Maryland 20850

[redacted]

SUBURB MD ROCKVILLE
PM
25 OCT 2005
20850
MD

PITNEY BOWES
0.39004
U.S. POSTAGE

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073709

PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

Type: Refile
User: bnolan

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0015785120515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY

STATE: MD

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code)

TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 05 30 2005

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY | FROM | TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | FROM | TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L847.0
2. L847.2
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

MEDICAL RECORDS ATTACHED

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06 15 2005 | 06 15 2005	11	01	99204		12	168 00	1				
2	06 15 2005 | 06 15 2005	11	04	72100		12	99 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 521061922 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO

28. TOTAL CHARGE: $ 267 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 267 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
MARK A. PETERSON, M.D.
SIGNED 10/26/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE-ROCKVILLE
9715 MEDICAL CTR DR.
SUITE 415
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO ASSOC
9715 MEDICAL CTR DR.
SUITE 415
ROCKVILLE, MD 20850 (301) 251-4143
PIN # GRP #521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPU

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073711

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BLACK LUNG AND FECA CLAIMS

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SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnishe incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPU: regulations.

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NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lun programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), an 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the service and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federa agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessar to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosure are made through routine uses for information contained in systems of records.

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You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of compute matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnis information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exceptio of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and wer personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and Stat funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control numbe The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 1 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the informatio collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 750 Security Boulevard, Baltimore, Maryland 21244-1850.

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SHADY GROVE ORTHOPAEDIC ASSOCIATES, PA

R. Marshall Ackerman, MD
Jeffrey F. Witte, MD
Steven L. Tuck, MD
Andrew W. Bender, MD
Robert W. Palmer, MD
Mark A. Peterson, MD
Brett R. Quigley, MD

6/15/2005 MAP 151210P DOB:

PRESENT ILLNESS: comes in today. She is a 30-year-old female who was involved in a motor vehicle accident on 5/30/2005. She was rear-ended on the way home to New York in Delaware. She was ambulatory at the scene. She did not really hurt at the scene, but the next day was having discomfort in the neck, went to Shady Grove Hospital after her boyfriend picked her up. She was evaluated and released. She went back a week later because of continued pain and stiffness in her neck and back. She had x-rays taken of her cervical spine which were normal and she was released. She is still complaining of pain in the neck and the back. She has also complained of pain in the right knee, but this apparently happened prior to the accident. She twisted her foot and hurt her knee at that time.

PHYSICAL EXAM: On exam today, she complains of a lot of discomfort in the cervical region. There is pain in the trapezial region. It does not radiate down the arms. She has very limited motion with attempts at movement of her neck because of the pain. Examination of her back shows she has tenderness along the lower lumbar region. She has good motion. No paraspinal spasms. She is neurovascularly intact in both upper and lower extremities.

X-RAYS: X-ray report of the neck was normal. X-rays of her lumbar spine were taken which were normal.

ASSESSMENT: CERVICAL AND LUMBAR STRAIN.

PLAN: I have discussed with her the diagnosis and treatment. I am going to start her on a short course of therapy. I have given her some Vicodin for pain. I told her at this point that I do not think there is any reason she couldn't try working with this though it may be uncomfortable. I would like to see her back in 2 weeks to see how she is doing. /vmq

Mark A. Peterson, M.D.

cc: PIP

9715 Medical Center Dr. | Suite 415 | Rockville, MD 20850 | Phone 301.340.9200 | Fax 301.340.7235

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ALLSTATE (SG) 073713

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA

9715 Medical Center Dr.
Suite 415
Rockville, Maryland 20850

ROCKVILLE MD
OCT 31 '05

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ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

CHJ 7

Type: Primary
User: DPILLITTERI

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
	(Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)
					X	

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0015785120515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY; SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY

STATE: NY

8. PATIENT STATUS: Single X Married Other; Employed X Full-Time Student Part-Time Student

CITY

STATE: NY

ZIP CODE

TELEPHONE (Include Area Code)

ZIP CODE

TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: ~~2125843108~~ 212584 3132

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY; SEX M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M F

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 05 30 2005

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY; FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY; FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO; $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L847.0
2. L847.2
3.
4.

22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 06152005 SCRIPT

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 22 2005	06 22 2005	11	01	97001		12	135 00	1				
2 06 22 2005	06 22 2005	11	01	97110		12	43 00	1				
3 06 22 2005	06 22 2005	11	01	97140		12	43 00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 521061922; SSN; EIN X

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES NO X

28. TOTAL CHARGE: $ 221 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 221 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
SANDRA F BIRNBAUM, P.T.
SIGNED PT15703 DATE 06/27/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850 (301) 294-1327
PIN # GRP 521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPI

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ALLSTATE (SG) 073716

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information n be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to proc the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signat authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group he insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigner CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full cha and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the cha determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in th items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure a diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnis incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMP regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervis by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physicia offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian emplo of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung clair I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subj to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lc programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), a 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the servic and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Fede agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessa to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosur are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishm of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupm claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be ma to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, clai adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil a criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discuss below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rende or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would de payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 38(3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of compu matches.

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ALLSTATE (SG) 073717

SHADY GROVE ORTHOPAEDIC ASSOCIATES, P.A.
PHYSICAL THERAPY DEPARTMENT

Patient: _ Date: 6.22.05

Diagnosis: Cervical/Lumbar Strain DOI/DOS:

History: pt is a 30y/o f reports MVA 5/31/05 + rear end (B) neck pain / (B) lumbar pain + scan (B) UE quad pain to the knees. x-rays: neck/chest/back results (-)

Patient Goals: ↓pain, ↑ADL

Functional Limitations
- turning head to look
- reaching overhead
- carry/lift 20 lbs.
- bend to pick up
- sit > 1 hr

Degree of Difficulty (Min Mod Max Unable)
- painful
- mod/severe
- mod
- mod
- mod

Pain level (0-10)
- neck 8 radiates to ballpark
- [illegible]

PMH: no allergies, family history of [illegible] pain, diabetes, hypertension, cancer, s/p 12/05

Meds: Vicodin, Valium, Aleve, unknown

Difficulty sleeping up to 2x/night — has to take pain meds

Objective:

Posture: Mod forward head, mod droopy shoulders, ↑thoracic kyphosis, head position SB (L).

Lumbar ROM: AROM Limitations	Left	Right
Flexion:	47 cm FTF*	
Extension:	25° *	
Rotation:	85°*	75°*
Side Bend:	9 cm*	5.3 cm*

CERV FB 60°* BG 42°* ROTR 25°* SBR 25°* SBL 25°* ROTL 20°*

Repetitive PROM	Left	Right
Flexion: x /x :	NT	
Extension: x /x :		
Right Rot: x /x :		
Left Rot: x /x :		
Passive SLR:	(L)	(L)

* Denotes Pain
**Denotes provocation of radicular symptoms

PROM end feel: pain spine lumbar → hips

*pain on, mvmt UE > LE

Flexibility:

Hip Flexors:	8° hip	6° hip
Hamstrings:	-28° ext	-27° ext
Gluteals:		
Piriformis:		
Quads:		

Sensory Testing:

(B) UE dermatomes intact
(B) UE's to lt. touch

Gross Muscle Strength:

L1-2 Hip Flexion:	4*	4* LD
L3 Knee Ext:	5	5 clapse LE & mvmt
L4 Ankle DF:	5	5
L5 Great Toe Ext:	5	5
S1 Ankle PF:	5	5
S2 Knee Flexion:	5	5

pt c/o neck/shoulder pain on mvmt (B) UE
(B) UE grossly 5/5 except wrist ext 3/5, mod tr ops 3+, lower trap 3/5
(R) UE grossly 5/5 except wrist ext 3/5 mod tr ops 3, lower trap 3

Palpation: min (B) UT tightness but not TP

Other Testing: tenderness (B) UT / cervical, mod hypomobility lumbar passive, TrPs tenderness (B), radiating tenderness (L) hip/groin

Treatment:

Today: Physical eval, HEP, ice to cervical → lumbar, then exp.

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Low BACK

Treatment:

Issued HEP of: SKC lower L (B) piriformis L (B) Cam, PPT, (B) LA (B) Quadratus

Assessment:

Pt. tolerated Rx. The pt dx Cervical/Lumbar strain to benefit from PT Rx to N abnormal muscle tightness + correct muscle imbalances + return to function

Pt. will benefit from P.T. for the following goals:

STG: Increase ☐ ROM ☐ Flexibility ☐ Strength
Decrease ☐ Pain 0/10 ☐ Tenderness ☐ Muscle Tone
☐ Improve ☐ Posture for: pt to 1½ hrs
☐ Function for: neck overhead
☐ Other: Tissue proper carry/lift 5 lbs.

LTG: ☐ Pt. will be able to pt 1½ - 2 hrs
☐ Pt. will be able to proper bend to pick up
☐ Pt. will be able to Demonstrate proper posture to do
☐ Other: HEP + sleep tissue tight neck
pt noted to do pain 0 all (most) activities

Plan:

☐ General Lumbar Stab./LE strengthening, flexibility, and conditioning program.
☐ Bike: ☐ Conditioning
☐ ROM: ☐ Extension ☐ Flexion ☐ Right Rot. ☐ Left Rot. ☐ Right SB ☐ Left SB
☐ Passive ☐ Active Assist ☐ Active
☐ Strengthening: ☐ Lumbar ☐ Abdominals ☐ Postural ☐ LE ☐ Other: mid/lower traps rhomboids
☐ Stabilization: ☐ Lumbar ☐ Pelvic
☐ Stretches: ☐ Hamstrings ☐ Hip Flexors ☐ Gluteals ☐ Piriformis ☐ Quads ☐ Other: UT levator
☐ Manual Therapy/Mobilizations/Soft Tissue Manipulation _____
☐ CUS to _____
☐ Pelvic Traction: ☐ Supine ☐ Prone
☐ E-stim: ☐ Pain ☐ Decrease Muscle Tone _____
☐ Cold ☐ Hot pack
☐ Postural Re-ed
☐ HEP
☐ Other: Reed

Precautions: _____

Signature: [signature]

9715 Medical Center Drive • Suite 202 • Rockville, Maryland 20850 • Phone: (301) 294-1327 • Fax: (301) 294-1337

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073719

15/210P

1/4

Shady Grove Orthopaedic Associates, P.A. - Physical Therapy Department

9715 Medical Center Drive Suite 202 Rockville, Maryland 20850
Phone: (301) 294-1327 Fax: (301) 294-1337

Patient: _____ Diagnosis: 847.0 / 847.2

Date: 6-22-05 Physician: Peterson

Insurance: PIP / SELF

See attached initial evaluation

Evaluation and Testing
- [ ] 97001 Initial Evaluation
- [ ] 97002 Re-evaluation
- [ ] 95851 Goniometry
- [ ] 95831 Muscle Testing

Modalities
- [ ] 97010 Cold/Hot pack
- [ ] 97012 Mechanical Traction
- [ ] 90714 Elec. Stim. unattended
- [ ] 97033 Iontophoresis
- [ ] 97035 Ultrasound/Phonophoresis
- [ ] G0283 Medicare Elec. Stim unattended

Procedures
- [ ] 97110 Therapeutic Exercise
- [ ] 97112 Neuromuscular Re-ed
- [ ] 97116 Gait Training
- [ ] 97124 Massage
  - *effleurage*
  - *petrissage*
  - *tapotement*
- [ ] 97140 Manual Therapy
  - *joint mobilization*
  - *manual traction*
  - *myofascial release*
- [ ] 97504 Orthotics Fitting and Training
- [ ] 97530 Therapeutic Activities
- [ ] 97535 ADL Training

Other
- [ ] 90001 Ionotophoresis Pads
- [ ] 90003 Theraband
- [ ] 90004 No Show
- [ ] ____ _____
- [ ] ____ _____

Sandra Bárbe PT
Therapist Signature

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073720

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA
9715 Medical Center Dr.
Suite 415
Rockville, Maryland 20850
ROCKVILLE MD
JUL 18 '05
PB METER
8491004
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$ 0.37

PLE[redacted]
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ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

2AW

Type: Primary
User: DPILLITTERI

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 0015785120515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE / SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE: NY

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY | STATE: NY

ZIP CODE | TELEPHONE (Include Area Code)

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: ~~2125843108~~ 212584 3132

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH | SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State)

b. EMPLC

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 05 30 2005 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L847.0
2. L847.2
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 06152005 SCRIPT

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 27 2005	06 27 2005	11	01	97110		1	43 00	1				
1 06 27 2005	06 27 2005	11	01	97140		1	86 00	2				
2												
3												
4												
5												
6												

-258.00

25. FEDERAL TAX I.D. NUMBER: 521061922 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [ ] NO [X]

28. TOTAL CHARGE: $ 129 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 129 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
SANDRA F BIRNBAUM, P.T.
SIGNED PB 103 DATE 07/01/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850 (301) 294-1327
PIN # GRP 521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CARRIER PATIENT AND INSURED INFORMATION

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073723

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED B APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information ma be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to proces the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signatur authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group healt insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 4 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned c CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charg and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charg determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program bu makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in thos items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure an diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnishe incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPU regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervisio by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employe of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claim I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subje to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lun programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), an 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the service and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Feder agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessar to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosure are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 5 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 2 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishmer of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/ the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupmer claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be mad to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil an criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discusse below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendere or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would dela payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 380 3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of comput matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnis information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exceptic of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and wer personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and Sta funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control numbe The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 1 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the informatic collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 75 Security Boulevard, Baltimore, Maryland 21244-1850.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073724

[redacted] Dr. Sandra F Birnbaum, P.T. 4:00 pm 6/27/2005 Superbill #: 67079
Co Pay: $0.00 Allstate Insurance

Acct ID: 151210P

Post Op: to

Last Visit: 6/22/2005 8470/847.2 Neck Sprain

C: $488.00 30: $0.00 60: $0.00 90: $0.00 120+: $0.00

2/4

Shady Grove Orthopaedic Associates, P.A. - Physical Therapy Department

9715 Medical Center Drive Suite 202 Rockville, Maryland 20850
Phone: (301) 294-1327 Fax: (301) 294-1337

S: P.T. reports ceilitis
bobber, but pinstick
neck + LBP.
O: MHP to cerv/trap
x15' prior to Rx:
Manual cer distract
Suboccipital release
Passive ROM cspine
(B) scap mobs; cer pads
PA glides thoracic
MHP | SDM cervical
Cervical CKC x 20'
then ex to SVC /
DCC: (B) prone
ER x30sec x2 (B)
Prone ER, (B) ext
ER x30sec each
Pyt x5; (B) LAT
+ (B) Quadr str Time to need x10
A/P: Pt to do pain during Rx session at PT.

Therapist Signature

Evaluation and Testing
[ ] 97001 Initial Evaluation
[ ] 97002 Re-evaluation
[ ] 95851 Goniometry
[ ] 95831 Muscle Testing

Modalities
[ ] 97010 Cold/Hot pack
[ ] 97012 Mechanical Traction
[ ] 97014 Elec. Stim. unattended
[ ] 97033 Iontophoresis
[ ] 97035 Ultrasound/Phonophoresis
[ ] G0283 Medicare Elec. Stim. unattended

Procedures
[ ] 97110 Therapeutic Exercise
[ ] 97112 Neuromuscular Re-ed
[ ] 97116 Gait Training
[ ] 97124 Massage
effleurage
petrissage
tapotement
[2] 97140 Manual Therapy
joint mobilization
manual traction
myofascial release
[ ] 97504 Orthotics Fitting and Training
[ ] 97530 Therapeutic Activities
[ ] 97535 ADL Training

Other
[ ] 90001 Iontophoresis Pads
[ ] 90003 Theraband
[ ] 90004 No Show
[ ] ____ ____
[ ] ____ ____

PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

Type: Primary
User: DPILLITTERI

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0015785120515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY; SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY

STATE: NY

8. PATIENT STATUS: Single X Married Other; Employed X Full-Time Student Part-Time Student

CITY

STATE: NY

ZIP CODE

TELEPHONE (Include Area Code)

ZIP CODE

TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 2125843108

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY; SEX: M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX: M F

b. AUTO ACCIDENT? YES X NO; PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 05 30 2005

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO; $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L847.0
2. L847.2
3.
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 06152005 SCRIPT

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 29 2005	06 29 2005	11	01	97110		1	43 00	1				
2 06 29 2005	06 29 2005	11	01	97140		1	86 00	2				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
521061922		X	151210P	YES NO	$ 129 00	$ 0 00	$ 129 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
SANDRA F BIRNBAUM, P.T.
SIGNED PT5703 DATE 07/01/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850 (301) 294-1327
PIN # GRP 521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073726

[redacted]

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BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure an diagnosis coding systems.

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NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

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DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

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I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073727

[redacted] Dr. Sandra Baum, P.T. 4:00 pm 6/29/2005 Superbill #: 67523
Co Pay: $0.00 Allstate Insurance

Acct ID: 151210P

Post Op: to

3/4

Last Visit: 6/22/2005 8470 847.2 Neck Sprain

C: $488.00 30: $0.00 60: $0.00 90: $0.00 120+: $0.00

Shady Grove Orthopaedic Associates, P.A. - Physical Therapy Department

9715 Medical Center Drive Suite 202 Rockville, Maryland 20850
Phone: (301) 294-1327 Fax: (301) 294-1337

S: Neck / back pain - much better, but flaring if sitting for a while. Is helping.
O: Suboccipital release
PROM WNL
Manual Tx
MFR SCM Cervicothoracic
PA Glides Thoracic
(Unable to do 20 min)
Abs Flex ex - D
ELEC IDEC
(B) Pec stretch
(B) Lat stretch
(B) Chest stretch
Prone (B) mid flexion
Rhomboid strengthening x10 ea
BAK / Cervical Sx
Pt may need Rx.
A/P: Please c/s.
Cont Rx.
Sandra Baum
Therapist Signature

Evaluation and Testing
[ ] 97001 Initial Evaluation
[ ] 97002 Re-evaluation
[ ] 95851 Goniometry
[ ] 95831 Muscle Testing

Modalities
[ ] 97010 Cold/Hot pack
[ ] 97012 Mechanical Traction
[ ] 97014 Elec. Stim. unattended
[ ] 97033 Iontophoresis
[ ] 97035 Ultrasound/Phonophoresis
[ ] G0283 Medicare Elec. Stim unattended

Procedures
[✓] 97110 Therapeutic Exercise
[ ] 97112 Neuromuscular Re-ed
[ ] 97116 Gait Training
[ ] 97124 Massage
effleurage
petrissage
tapotement
[2] 97140 Manual Therapy
joint mobilization
manual traction
myofascial release
[ ] 97504 Orthotics Fitting and Training
[ ] 97530 Therapeutic Activities
[ ] 97535 ADL Training

Other
[ ] 90001 Iontophoresis Pads
[ ] 90003 Theraband
[ ] 90004 No Show
[ ] ____ ____
[ ] ____ ____

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073728

PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

CHJ7

Type: Primary
User: DPILLITTERI

HEALTH INSURANCE CLAIM FORM

PICA | RICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare #) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)
X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0015785120515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE | SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single X | Married | Other
Employed X | Full-Time Student | Part-Time Student

CITY | STATE: NY

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (INCLUDING AREA CODE): (631) 404-0014

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 2125843108 212584310252

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO X

a. INSURED'S DATE OF BIRTH | SEX: M | F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. AUTO ACCIDENT? YES X | NO | PLACE (State)

b. EM | OL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X. If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
05 30 2005

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY | MM DD YY
FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | MM DD YY
FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X | $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 847.0
2. 847.2
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 06152005 SCRIPT

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 06 2005	07 06 2005	11	01	97110		1	43 00	1				
2 07 06 2005	07 06 2005	11	01	97140		1	86 00	2				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 521061922 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES | NO X

28. TOTAL CHARGE: $ 129 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 129 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
SANDRA F BIRNBAUM, P.T.
SIGNED PT15703 DATE 07/11/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850 (301) 294-1327
PIN # GRP 521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPI

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073729

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information n be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to proc the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signat authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group he insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assignec CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full char and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the cha determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in the items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure a diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnish incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMP regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervisi by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physicia offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employ of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claim I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subje to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lu programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), a 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the servio and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Feder agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessa to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosur are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 2 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishme of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/ the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupme claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be mac to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil ar criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discusse below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendere or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would dela payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 380 3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of compute matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnis information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exceptio of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and wer personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and Stat funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control numbe The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 1 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the informatio collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 750 Security Boulevard, Baltimore, Maryland 21244-1850.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073730

Shady Grove Orthopaedic Associates, P.A.
Physical Therapy Department

9715 Medical Center Drive • Suite 202 • Rockville, Maryland 20850
Phone: 301-294-1327 Fax: 301-294-1337

Patient: _____ Date: 6/15/08

Diagnosis: Cervical & lumbar strain Date of Illness/Surgery: _____

Precautions/Specific Instructions: Pain + strength

Frequency: 1 2 3 4 5 sessions/week for 1 2 3 4 ___ weeks Follow-up Appointment: _____ weeks

☐ Cervical ☐ Lumbar – Spine
☐ Cervicalgia
☐ Lumbago
☐ Spondylosis
☐ Disc: ☐ Degen. ☐ HNP _____
☐ Radiculopathy: ☐ Left ☐ Right
☐ Stenosis

☐ Shoulder: ☐ Left ☐ Right
☐ RC Tendonitis
☐ Adhesive Capsulitis
☐ Sprain/Strain
☐ Impingement
☐ Instability: ☐ Ant. ☐ Post. ☐ Multi
☐ Dislocation ☐ Subluxation
☐ Fracture: _____
☐ Total Shoulder Replacement

☐ Elbow: ☐ Left ☐ Right
☐ Epicondylitis: ☐ Lat. ☐ Med.
☐ Sprain/Strain: ☐ Ulnar ☐ Radial
☐ Fracture: _____

☐ Wrist: ☐ Left ☐ Right
☐ Carpal Tunnel
☐ Arthritis
☐ Fracture: ☐ Colles
☐ Other: _____

☐ Hip: ☐ Left ☐ Right
☐ Trochanteric Bursitis
☐ Osteoarthritis
☐ Total Hip Replacement

☐ Knee: ☐ Left ☐ Right
☐ ACL Tear: ☐ Partial ☐ Full
☐ Meniscus: ☐ Med. ☐ Lat.
☐ Patellofemoral Pain Syndrome
☐ Patellar Instability: ☐ Sublux. ☐ Disloc.
☐ MCL Sprain: Grade _____
☐ Patellar Tendonitis
☐ Osteoarthritis
☐ Plicae
☐ Iliotibial Band Syndrome
☐ Total Knee Replacement

☐ Ankle: ☐ Left ☐ Right
☐ Sprain: ☐ Inversion ☐ Eversion
☐ Tendonitis: ☐ Achilles ☐ Peroneals
☐ Achilles Rupture
☐ Fracture: _____

Modalities and Procedures

☐ Evaluate and Treat

☐ Modalities
☐ Cold/Hot Packs
☐ Ultrasound
☐ Phonophoresis
☐ Iontophoresis
☐ Electrical Stimulation
☐ Soft Tissue Manipulation
☐ Manual Therapy
☐ Traction: ☐ Cerv ☐ Lumbar

☐ Strengthening
☐ Isometric
☐ Isotonic
☐ P.R.E.
☐ Range of Motion
☐ Passive
☐ Active Assist
☐ Active

☐ Stretching _____
☐ PF Taping
☐ Proprioception
☐ Lumbar Stabilization
☐ Posture/Mechanics
☐ Williams Flexion
☐ McKenzie Extension
☐ Gait Training: ☐ NWB ☐ TT ☐ WBAT
☐ Home Exercise Program
☐ Other: _____

Physician's Signature: _____

Disclosure Statement

This is to notify you that Shady Grove Orthopaedic Associates, P.A. Physical Therapy Department is a wholly owned department of Shady Grove Orthopaedic Associates, P.A. We believe our facility provides the highest quality of physical therapy, however, you are free to obtain physical therapy services from any licensed practitioner.

Acknowledged: _____

This document certifies that the prescribed physical therapy is a medical necessity.

PTD-2

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073731

Dr. Sandra F Birnbaum, P.T. 12:30 pm 7/6/2005 Superbill #: 68167
Co Pay: $0.00 Allstate Insurance

Acct ID: 151210P

Post Op: to 4/4

Last Visit: 6/29/2005 8470 Neck Sprain

C: $746.00 30: $0.00 60: $0.00 90: $0.00 120+: $0.00

Shady Grove Orthopaedic Associates, P.A. - Physical Therapy Department

9715 Medical Center Drive Suite 202 Rockville, Maryland 20850
Phone: (301) 294-1327 Fax: (301) 294-1337

S: Pt states little (OK's permit)
better - lt still
neck & LBP better
pain right now walking 1 pain: 3 of 2 hrs
O: Allen: lateral FR 30 on R
BB 30° SB R 40 on SB L 45 on
Rot R 85% Rot L 85% *
Cervical Allen FR 19° BB 58% *
SB L 40° * SB R 40° Rot L 60° *
Rot R 60° *
Palpation: TP tenderness in
trapezius (R) UT / lumbar
paraspinals
Manual tx / suboccipital
release PRN C-Spine,
mobs LSpine c-> lumbar
Ther ex -> see (DNL / (R)
printout / slant board
(R) cat (camel) / lumbar ROM exercises
A&P: Hum on lumbar pt'd lt pain limitation
rent. Suggest ct PT R/W x 2 wks.

Therapist Signature

Evaluation and Testing			
[ ]	97001	Initial Evaluation	
[ ]	97002	Re-evaluation	
[ ]	95851	Goniometry	
[ ]	95831	Muscle Testing	
Modalities			
[ ]	97010	Cold/Hot pack	
[ ]	97012	Mechanical Traction	
[ ]	97014	Elec. Stim. unattended	
[ ]	97033	Iontophoresis	
[ ]	97035	Ultrasound/Phonophoresis	
[ ]	G0283	Medicare Elec. Stim unattended	
Procedures			
[4]	97110	Therapeutic Exercise	
[ ]	97112	Neuromuscular Re-ed	
[ ]	97116	Gait Training	
[ ]	97124	Massage	*effleurage, petrissage, tapotement*
[2]	97140	Manual Therapy	*joint mobilization, manual traction, myofascial release*
[ ]	97504	Orthotics Fitting and Training	
[ ]	97530	Therapeutic Activities	
[ ]	97535	ADL Training	
Other			
[ ]	90001	Iontophoresis Pads	
[ ]	90003	Theraband	
[ ]	90004	No Show	
[ ]	____	____	
[ ]	____	____	

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073732

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA
9715 Medical Center Dr.
Suite 415
Rockville, Maryland 20850
U.S. POSTAGE
PB METER
8491004
0.37
JUL 18 05
MD

PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

Type: Refile
User: bnolan

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
	(Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0015785120515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE: SEX M [ ] F [X]

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S NAME (Last Name, First Name, Middle Initial)

STATE: MD

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
Employed [X] Full-Time Student [ ] Part-Time Student [ ]

STATE: MD

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 2125843108 → 212584 3132

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: M [ ] SEX F [X]

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY | M [ ] SEX F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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AUTOMATED SIGNATURE
SANDRA F BIRNBAUM, P.T.
SIGNED: PT 15763 DATE: 10/25/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850

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9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850 (301) 294-1327
PIN # GRP # 521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS

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ALLSTATE (SG) 073735

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No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subje to fine and imprisonment under applicable Federal laws.

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(PRIVACY ACT STATEMENT)

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The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the servio and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Fede agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessa to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosur are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 2 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishme of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/ the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupme claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be mac to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, clair adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability; coordination of benefits, and civil a criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discusse below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services render or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would del payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 380 3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of comput matches.

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I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnit information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exceptic of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and we personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and Sta funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control numbe The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the informatic collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 75 Security Boulevard, Baltimore, Maryland 21244-1850.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073736

Shady Grove Orthopaedic Associates,
Physical Therapy Department

9715 Medical Center Drive • Suite 202 • Rockville, Maryland 20850
Phone: 301-294-1327 Fax: 301-294-1337

Patient: ___ Date: 6/15/08

Diagnosis: Cervical & lumbar strain Date of Illness/Surgery: _____

Precautions/Specific Instructions: Pain + strength

Frequency: 1 2 3 4 5 sessions/week for 1 2 3 4 ___ weeks Follow-up Appointment: _____ weeks

☐ **Cervical** ☐ **Lumbar – Spine**
☐ Cervicalgia
☐ Lumbago
☐ Spondylosis
☐ Disc: ☐ Degen. ☐ HNP _____
☐ Radiculopathy: ☐ Left ☐ Right
☐ Stenosis

☐ **Shoulder:** ☐ **Left** ☐ **Right**
☐ RC Tendonitis
☐ Adhesive Capsulitis
☐ Sprain/Strain
☐ Impingement
☐ Instability: ☐ Ant. ☐ Post. ☐ Multi
☐ Dislocation ☐ Subluxation
☐ Fracture: _____
☐ Total Shoulder Replacement

☐ **Elbow:** ☐ **Left** ☐ **Right**
☐ Epicondylitis: ☐ Lat. ☐ Med.
☐ Sprain/Strain: ☐ Ulnar ☐ Radial
☐ Fracture: _____

☐ **Wrist:** ☐ **Left** ☐ **Right**
☐ Carpal Tunnel
☐ Arthritis
☐ Fracture: ☐ Colles
☐ Other: _____

☐ **Hip:** ☐ **Left** ☐ **Right**
☐ Trochanteric Bursitis
☐ Osteoarthritis
☐ Total Hip Replacement

☐ **Knee:** ☐ **Left** ☐ **Right**
☐ ACL Tear: ☐ Partial ☐ Full
☐ Meniscus: ☐ Med. ☐ Lat.
☐ Patellofemoral Pain Syndrome
☐ Patellar Instability: ☐ Sublux. ☐ Disloc.
☐ MCL Sprain: Grade _____
☐ Patellar Tendonitis
☐ Osteoarthritis
☐ Plicae
☐ Iliotibial Band Syndrome
☐ Total Knee Replacement

☐ **Ankle:** ☐ **Left** ☐ **Right**
☐ Sprain: ☐ Inversion ☐ Eversion
☐ Tendonitis: ☐ Achilles ☐ Peroneals
☐ Achilles Rupture
☐ Fracture: _____

Modalities and Procedures

☐ **Evaluate and Treat**

☐ **Modalities**
☐ Cold/Hot Packs
☐ Ultrasound
☐ Phonophoresis
☐ Iontophoresis
☐ Electrical Stimulation
☐ Soft Tissue Manipulation
☐ Manual Therapy
☐ Traction: ☐ Cerv. ☐ Lumbar

☐ **Strengthening**
☐ Isometric
☐ Isotonic
☐ P.R.E.
☐ **Range of Motion**
☐ Passive
☐ Active Assist
☐ Active

☐ Stretching _____
☐ PF Taping
☐ Proprioception
☐ Lumbar Stabilization
☐ Posture/Mechanics
☐ Williams Flexion
☐ McKenzie Extension
☐ Gait Training: ☐ NWB ☐ TT ☐ WBAT
☐ Home Exercise Program
☐ Other: _____

Physician's Signature: _____

Disclosure Statement

This is to notify you that Shady Grove Orthopaedic Associates, P.A. Physical Therapy Department is a wholly owned department of Shady Grove Orthopaedic Associates, P.A. We believe our facility provides the highest quality of physical therapy, however, you are free to obtain physical therapy services from any licensed practitioner.

Acknowledged: _____

This document certifies that the prescribed physical therapy is a medical necessity.

PTD-2

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073737

Dr. Sandra F Birnbaum, P.T. 4:00 pm 6/29/2005 Superbill #: 67523
Co Pay: $0.00 Allstate Insurance

Acct ID: 151210P

3/4

Post Op: to

Last Visit: 6/22/2005 8470 847.2 Neck Sprain

C: $488.00 30: $0.00 60: $0.00 90: $0.00 120+: $0.00

Shady Grove Orthopaedic Associates, P.A. - Physical Therapy Department

9715 Medical Center Drive Suite 202 Rockville, Maryland 20850
Phone: (301) 294-1327 Fax: (301) 294-1337

S: Neck & back pain
mainly, but things
seem to be helping.
O: Suboccipital release
PROM cspine
Manual cspine tx
MHP SCM cervicothoracic
PA glides thoracic
Cont. x 20 min
Flexion ex
SLC, IDEC
Pectoralis stretch
Neck stretch
Chest stretch
Prone B mid Herex
Rhomboid strengthening x10 ea.
Brief Review of
Home program reviewed.
A/P: Please continue tx.
Cont Rx.

Andrea Paul
Therapist Signature

Evaluation and Testing
[ ] 97001 Initial Evaluation
[ ] 97002 Re-evaluation
[ ] 95851 Goniometry
[ ] 95831 Muscle Testing

Modalities
[ ] 97010 Cold/Hot pack
[ ] 97012 Mechanical Traction
[ ] 97014 Elec. Stim. unattended
[ ] 97033 Iontophoresis
[ ] 97035 Ultrasound/Phonophoresis
[ ] G0283 Medicare Elec. Stim unattended

Procedures
[Y] 97110 Therapeutic Exercise
[ ] 97112 Neuromuscular Re-ed
[ ] 97116 Gait Training
[ ] 97124 Massage
effleurage
petrissage
tapotement
[2] 97140 Manual Therapy
joint mobilization
manual traction
myofascial release
[ ] 97504 Orthotics Fitting and Training
[ ] 97530 Therapeutic Activities
[ ] 97535 ADL Training

Other
[ ] 90001 Iontophoresis Pads
[ ] 90003 Theraband
[ ] 90004 No Show
[ ] ____ ____
[ ] ____ ____

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ALLSTATE (SG) 073738

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA
9715 Medical Center Dr.
Suite 415
Rockville, Maryland 20850
ROCKVILLE MD
OCT 27 '05
PB METER
0.37

PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

2010

Type: Primary
User: JROBERTS

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER: 0015785120515 (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

SEX: M [ ] F [X]

3. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

STATE: NY

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
Employed [X] Full-Time Student [ ] Part-Time Student [ ]

STATE: NY

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: ~~212584310~~ 212584312

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | M [ ] SEX F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L847.0
2. L847.2
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: MEDICARE RECORDS ATTACHED

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 29 2005	06 29 2005	11	01	99213		1	100 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 521061922 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
MARK A. PETERSON, M.D.
SIGNED 07/06/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE - GERMANTOWN
9715 MEDICAL CTR
SUITE 415
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO ASSOC
9715 MEDICAL CTR DR.
SUITE 415
ROCKVILLE, MD 20850 (301) 251-4143
PIN # GRP # 521061922

14

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073741

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information n be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to proc the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signat authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group hea insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assignec CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full char and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the cha determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program t makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in the items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure a diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnish incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPI regulations.

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073742

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA

R. Marshall Ackerman, MD
Jeffrey F. Witte, MD
Steven L. Tuck, MD

Andrew W. Be
Robert W. Pa
Mark A. Pete
Brett R. Qui

06/29/05 MAP 151210P DOB:

returns today for follow-up of her neck and her back. She is making some progress with therapy, though she is still very stiff.

On exam, she still complains of stiffness with rotation, but no radicular pain.

ASSESSMENT: CERVICAL LUMBAR STRAIN.

PLAN: At this point she is making slow progress. I told her to continue with therapy. She may try to continue working, even though she has some discomfort. I told her this will not cause any further problems to her neck or back. I will see her back in four weeks if she is still living in town, otherwise I will see her back on an as-needed basis. /syp

Mark A. Peterson, M.D.

cc: PIP

9715 Medical Center Dr. | Suite 415 | Rockville, MD 20850 | Phone 301.340.9200 | Fax 301.340.7225

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073743

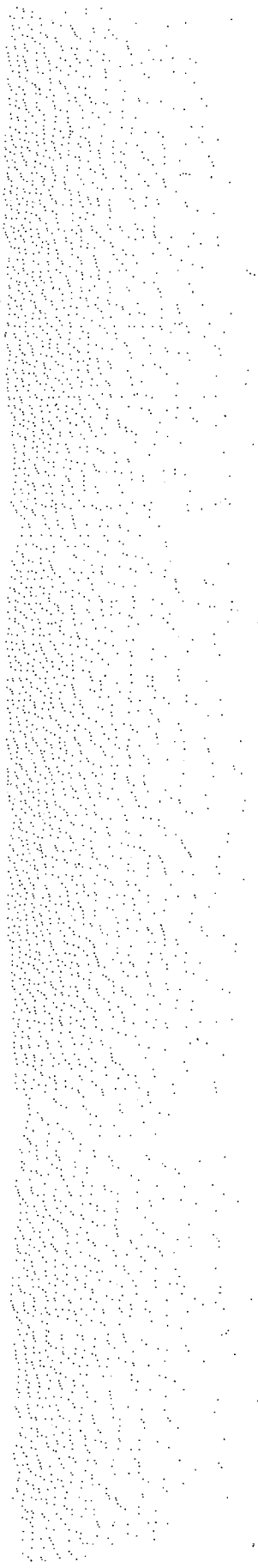
STUDY GROVE ORTHOPAEDIC ASSOCIATES P.A.
PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE VEHICLE IN WHICH YOU WERE DRIVING OR RIDING
AUTO ACCIDENT INFORMATION
PLEASE READ & SIGN
PLEASE COMPLETE THE FOLLOWING AUTO INFORMATION IF THIS CLAIM IS UNDER MAJ/MAJ NO FAULT PERSONAL INJURY PROTECTION (PIP) COVERAGE
THIRD PARTY LIABILITY
ATTORNEY INFORMATION
WORKMAN'S COMPENSATION INFORMATION
FACE USE

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA

9715 Medical Center Dr.
Suite 415
Rockville, Maryland 20850

ROCKVILLE MD
JUL 20 '05
PB METER
8491004
U.S. POSTAGE
$0.37

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073745



PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

Type: Refile
User: bnolan

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 001578512O515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

6. INSURED'S ADDRESS (No., Street) STATE: MD

7. INSURED'S ADDRESS (No., Street) STATE: MD

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 2125843108

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 05 30 2005 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L847.0
2. L847.2
3. L
4. L

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 06152005 SCRIPT

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
06 29 2005	06 29 2005	11	01	97110		1	43 00	1				
06 29 2005	06 29 2005	11	01	97140		1	86 00	2	43.00			

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 521061922

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [ ] NO [X]

28. TOTAL CHARGE $ 129 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 129 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
SANDRA F BIRNBAUM, P.T.
SIGNED [illegible] DATE 10/26/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850 (301) 294-1327
PIN # GRP #521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMP

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073747

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register, Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the service/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veteran's Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073748

Shady Grove Orthopaedic Associates,
Physical Therapy Department

9715 Medical Center Drive • Suite 202 • Rockville, Maryland 20850
Phone: 301-294-1327 Fax: 301-294-1337

Patient: ___ Date: 6/15/08

Diagnosis: Cervical & lumbar strain Date of Illness/Surgery: ___

Precautions/Specific Instructions: Rom + strength

Frequency: 1 2 3 4 5 sessions/week for 1 2 3 4 ___ weeks Follow-up Appointment: ___ weeks

☐ **Cervical** ☐ **Lumbar – Spine**
☐ Cervicalgia
☐ Lumbago
☐ Spondylosis
☐ Disc: ☐ Degen. ☐ HNP ___
☐ Radiculopathy: ☐ Left ☐ Right
☐ Stenosis

☐ **Shoulder:** ☐ **Left** ☐ **Right**
☐ RC Tendonitis
☐ Adhesive Capsulitis
☐ Sprain/Strain
☐ Impingement
☐ Instability: ☐ Ant. ☐ Post. ☐ Multi
☐ Dislocation ☐ Subluxation
☐ Fracture: ___
☐ Total Shoulder Replacement

☐ **Elbow:** ☐ **Left** ☐ **Right**
☐ Epicondylitis: ☐ Lat. ☐ Med.
☐ Sprain/Strain: ☐ Ulnar ☐ Radial
☐ Fracture: ___

☐ **Wrist:** ☐ **Left** ☐ **Right**
☐ Carpal Tunnel
☐ Arthritis
☐ Fracture: ☐ Colles
☐ Other: ___

☐ **Hip:** ☐ **Left** ☐ **Right**
☐ Trochanteric Bursitis
☐ Osteoarthritis
☐ Total Hip Replacement

☐ **Knee:** ☐ **Left** ☐ **Right**
☐ ACL Tear: ☐ Partial ☐ Full
☐ Meniscus: ☐ Med. ☐ Lat.
☐ Patellofemoral Pain Syndrome
☐ Patellar Instability: ☐ Sublux. ☐ Disloc
☐ MCL Sprain: Grade ___
☐ Patellar Tendonitis
☐ Osteoarthritis
☐ Plicae
☐ Iliotibial Band Syndrome
☐ Total Knee Replacement

☐ **Ankle:** ☐ **Left** ☐ **Right**
☐ Sprain: ☐ Inversion ☐ Eversion
☐ Tendonitis: ☐ Achilles ☐ Peroneals
☐ Achilles Rupture
☐ Fracture: ___

Modalities and Procedures

☐ **Evaluate and Treat**

☐ **Modalities**
☐ Cold/Hot Packs
☐ Ultrasound
☐ Phonophoresis
☐ Iontophoresis
☐ Electrical Stimulation
☐ Soft Tissue Manipulation
☐ Manual Therapy
☐ Traction: ☐ Cerv. ☐ Lumbar

☐ **Strengthening**
☐ Isometric
☐ Isotonic
☐ P.R.E.
☐ **Range of Motion**
☐ Passive
☐ Active Assist
☐ Active

☐ Stretching ___
☐ PF Taping
☐ Proprioception
☐ Lumbar Stabilization
☐ Posture/Mechanics
☐ Williams Flexion
☐ McKenzie Extension
☐ Gait Training: ☐ NWB ☐ TT ☐ WBAT
☐ Home Exercise Program
☐ Other: ___

Physician's Signature: [signature]

Disclosure Statement

This is to notify you that Shady Grove Orthopaedic Associates, P.A. Physical Therapy Department is a wholly owned department of Shady Grove Orthopaedic Associates, P.A. We believe our facility provides the highest quality of physical therapy, however, you are free to obtain physical therapy services from any licensed practitioner.

Acknowledged: ___

This document certifies that the prescribed physical therapy is a medical necessity.

PTD-2

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073749

Dr. Sandra F. Birnbaum, P.T. 4:00 pm 6/29/2005 Superbill #: 67523
Co Pay: $0.00 Allstate Insurance

Acct ID: 151210P

3/4

Post Op: to

Last Visit: 6/22/2005 8470 847.2 Neck Sprain

C: $488.00 30: $0.00 60: $0.00 90: $0.00 120+: $0.00

Shady Grove Orthopaedic Associates, P.A. - Physical Therapy Department

9715 Medical Center Drive Suite 202 Rockville, Maryland 20850
Phone: (301) 294-1327 Fax: (301) 294-1337

S: Neck / back pain
much better
pain is helping
O: Suboccipital release
PROM WNL
Manual Tx
MFR STM cervical
PA glide thoracic
(unable to do)
Shoulder ex
ABC / DBC
Pectoralis stretch
Levator stretch
Scalene stretch
Prone B mid flexion
Rhomboid strengthening x10 each
Brief Review of HEP
Ice pack recommended
A/P: Pain & ex.
Cont Rx:
Therapist Signature

Evaluation and Testing
- [ ] 97001 Initial Evaluation
- [ ] 97002 Re-evaluation
- [ ] 95851 Goniometry
- [ ] 95831 Muscle Testing

Modalities
- [ ] 97010 Cold/Hot pack
- [ ] 97012 Mechanical Traction
- [ ] 97014 Elec. Stim. unattended
- [ ] 97033 Iontophoresis
- [ ] 97035 Ultrasound/Phonophoresis
- [ ] G0283 Medicare Elec. Stim unattended

Procedures
- [4] 97110 Therapeutic Exercise
- [ ] 97112 Neuromuscular Re-ed
- [ ] 97116 Gait Training
- [ ] 97124 Massage
  effleurage
  petrissage
  tapotement
- [2] 97140 Manual Therapy
  joint mobilization
  manual traction
  myofascial release
- [ ] 97504 Orthotics Fitting and Training
- [ ] 97530 Therapeutic Activities
- [ ] 97535 ADL Training

Other
- [ ] 90001 Iontophoresis Pads
- [ ] 90003 Theraband
- [ ] 90004 No Show
- [ ] ____ _____
- [ ] ____ _____

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ALLSTATE (SG) 073750

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073751

PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

01

Type: Primary

User: DPILLITTERI

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 00157851205I5

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) | CITY | STATE NY | ZIP CODE | TELEPHONE (INCLUDING AREA CODE)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street) | CITY | STATE NY | ZIP CODE | TELEPHONE (INCLUDING AREA CODE)

8. PATIENT STATUS: Single X | Married | Other

Employed X | Full-Time Student | Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: ~~2125843188~~ 262584313

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES X | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X — *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X — $ CHARGES: 0 00

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1. 847.0
2. 847.2
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 07112005 SCRIPT

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	07 11 2005 | 07 11 2005	11	01	97110		1	43 00	1				
2	07 11 2005 | 07 11 2005	11	01	97140		1	86 00	2				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 521061922 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES | NO X

28. TOTAL CHARGE: $ 129 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 129 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
SANDRA F BIRNBAUM, P.T.
SIGNED PT 5703 DATE 07/18/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850

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ROCKVILLE, MD 20850 (301) 294-1327
PIN # GRP # 521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPU

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073753

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The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the servi and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Fede agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necess to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosu are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishm of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services an the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representatio the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupm claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be m to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, cla adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discus below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rend or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would d payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3 3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of comp matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to fu information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exce of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control nu The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to averag minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the inform collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26 2 Security Boulevard, Baltimore, Maryland 21244-1850.

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ALLSTATE (SG) 073754

Dr. Sandra F Birnbaum, P.T. 4:00 pm 7/11/2005 Superbill #: 68787
Co Pay: $0.00 Allstate Insurance

Acct ID: 151210P

Post Op: to

1/6

Last Visit: 7/6/2005 8470 Neck Sprain

C: $975.00 30: $0.00 60: $0.00 90: $0.00 120+: $0.00

Shady Grove Orthopaedic Associates, P.A. - Physical Therapy Department

9715 Medical Center Drive Suite 202 Rockville, Maryland 20850
Phone: (301) 294-1327 Fax: (301) 294-1337

S: Back sore from sitting in car – drove up to N.Y. on weekend
O: Thoracic con tp, subscapular release
Rib region
(B) scap mobs
(B) cervical pulls, STM/MFR cervical → Dunbar
Thor ex →
Bryan Cert Ax x5
Lum Ax x2 + Estim
Elec IFC
(B) prone press Thor ext stretch
(B) UT release Ax
MHP heat Thor x5'
Ap: Tolerated Rx
little better today
Cont to progress.
Sandra Baird OT
Therapist Signature

Evaluation and Testing
[ ] 97001 Initial Evaluation
[ ] 97002 Re-evaluation
[ ] 95851 Goniometry
[ ] 95831 Muscle Testing

Modalities
[ ] 97010 Cold/Hot pack
[ ] 97012 Mechanical Traction
[ ] 97014 Elec. Stim. unattended
[ ] 97033 Iontophoresis
[ ] 97035 Ultrasound/Phonophoresis
[ ] G0283 Medicare Elec. Stim unattended

Procedures
[4] 97110 Therapeutic Exercise
[ ] 97112 Neuromuscular Re-ed
[ ] 97116 Gait Training
[ ] 97124 Massage
effleurage
petrissage
tapotement
[2] 97140 Manual Therapy
joint mobilization
manual traction
myofascial release
[ ] 97504 Orthotics Fitting and Training
[ ] 97530 Therapeutic Activities
[ ] 97535 ADL Training

Other
[ ] 90001 Iontophoresis Pads
[ ] 90003 Theraband
[ ] 90004 No Show
[ ] ____ _____
[ ] ____ _____

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ALLSTATE (SG) 073755

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA

9715 Medical Center Dr.
Suite 415
Rockville, Maryland 20850

ROCKVILLE MD
JUL 26 '05
PB METER
849004
U.S. POSTAGE
$00.37

PLEASE DO NOT STAPLE IN THIS AREA

ALLSTATE INSURANCE
1 INDEPENDENT HILL
#201
FARMINGVILLE, NY 11738

Type: Primary
User: DPILLITTERI

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0015785120515

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) | STATE: NY

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street) | STATE: NY

8. PATIENT STATUS: Single X | Married | Other
Employed X | Full-Time Student | Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO X
b. AUTO ACCIDENT? YES X | NO | PLACE (State)
c. OTHER ACCIDENT? YES | NO X
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: 2125843108
a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F X
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE INSURANCE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 06/15/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 05 30 2005

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PETERSON, MARK, A

17a. I.D. NUMBER OF REFERRING PHYSICIAN: E54868

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. L847.0
2. L847.2
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 07112005 SCRIPT

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
07 13 2005	07 13 2005	11	01	97110		1	43 00	1				
07 13 2005	07 13 2005	11	01	97140		1	86 00	2				

25. FEDERAL TAX I.D. NUMBER: 521061922 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 151210P

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES | NO

28. TOTAL CHARGE: $ 129 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 129 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
AUTOMATED SIGNATURE
SANDRA F BIRNBAUM, P.T.
SIGNED P115103 07/21/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SHADY GROVE ORTHO PT DEPT
9715 MEDICAL CTR D
SUITE 202
ROCKVILLE, MD 20850 (301) 294-1327
PIN # GRP # 521061922

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMP

CONFIDENTIAL
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ALLSTATE (SG) 073758

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED E APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information ma be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to proce the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signatu authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group heal insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 4 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charg and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charg determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program b makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in thos items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure an diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnishe incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPU regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervisio by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician' offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employe of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subjec to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federa agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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ALLSTATE (SG) 073759

Dr. Sandra F Birnbaum, P.T. 4:00 pm 7/13/2005 Superbill #: 69402
Co Pay: $0.00 State Insurance

Acct ID: 151210P

Post Op: to

2/6

Last Visit: 7/8/2005 8470 Neck Sprain

C: $980.00 30: $0.00 60: $0.00 90: $0.00 120+: $0.00

Shady Grove Orthopaedic Associates, P.A. - Physical Therapy Department

9715 Medical Center Drive Suite 202 Rockville, Maryland 20850
Phone: (301) 294-1327 Fax: (301) 294-1337

S: Neck feeling better, but back pain persists.
O: Manual cx tx
suboccipital release
PROM c-spine
(B) SCM spasm
(B) UT pulls
MFR/STM cx → lower
more tenderness/knots
lower prox to Rx;
then ex →
(B) UT (lenator str
SLR 2 DKC, (B) piriformis
(B) glut (B) hamstr
PPT x10, 2 pain (B) mid
trap, lower trapezius
MPR to bilateral UT
tenderness (B) UT, bilat tp tenderness/
pain points lower paraesp.
Cont PT.

Sandra Birnbaum PT
Therapist Signature

Evaluation and Testing

[ ]	97001	Initial Evaluation
[ ]	97002	Re-evaluation
[ ]	95851	Goniometry
[ ]	95831	Muscle Testing

Modalities

[ ]	97010	Cold/Hot pack
[ ]	97012	Mechanical Traction
[ ]	97014	Elec. Stim. unattended
[ ]	97033	Iontophoresis
[ ]	97035	Ultrasound/Phonophoresis
[ ]	G0283	Medicare Elec. Stim unattended

Procedures

[✓]	97110	Therapeutic Exercise
[ ]	97112	Neuromuscular Re-ed
[ ]	97116	Gait Training
[ ]	97124	Massage *effleurage* *petrissage* *tapotement*
[2]	97140	Manual Therapy *joint mobilization* *manual traction* *myofascial release*
[ ]	97504	Orthotics Fitting and Training
[ ]	97530	Therapeutic Activities
[ ]	97535	ADL Training

Other

[ ]	90001	Iontophoresis Pads
[ ]	90003	Theraband
[ ]	90004	No Show
[ ]	____	_____
[ ]	____	_____

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ALLSTATE (SG) 073760

SHADY GROVE
ORTHOPAEDIC
ASSOCIATES, PA
9715 Medical Center Dr.
Suite 415
Rockville, Maryland 20850
ROCKVILLE MD
JUL 25 '05
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00.37

ALLSTATE
888 VETERANS HWY
SUITE 300
HAUPPAUGE, NY 11788

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APPROVED OMB-0938-0008

11/HHJ7

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☒ (ID)

1a. INSURED'S I.D. NUMBER: 212584313224W (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE: MM DD YY — SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY

STATE: MD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE

TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): MD

b. EMPLOYER'S NAME OR SCHOOL NAME: CLEANING AUTHORITY

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09/20/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 09 20 2005 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: BRETT GAMMA MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: OTH000

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V22.1
2. 625.9
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 20 2005	09 20 2005	23	4	76815	26	1,2	139.50	1				
2 09 20 2005	09 20 2005	23	4	76817	26	1,2	254.00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 52-1148069 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 500861835

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 393.50

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 393.50

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

BRUCE J BORTNICK MD

SIGNED 10/24/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SHADY GROVE ADV HOSP
9901 MEDICAL CENTER DR
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SHADY GROVE RADIOLOGICAL
PO BOX 17124
BALTIMORE, MD 21297

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CH

Restart # (1) Form (PRI) Line (DF) Sta [ ]

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073763

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed. Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

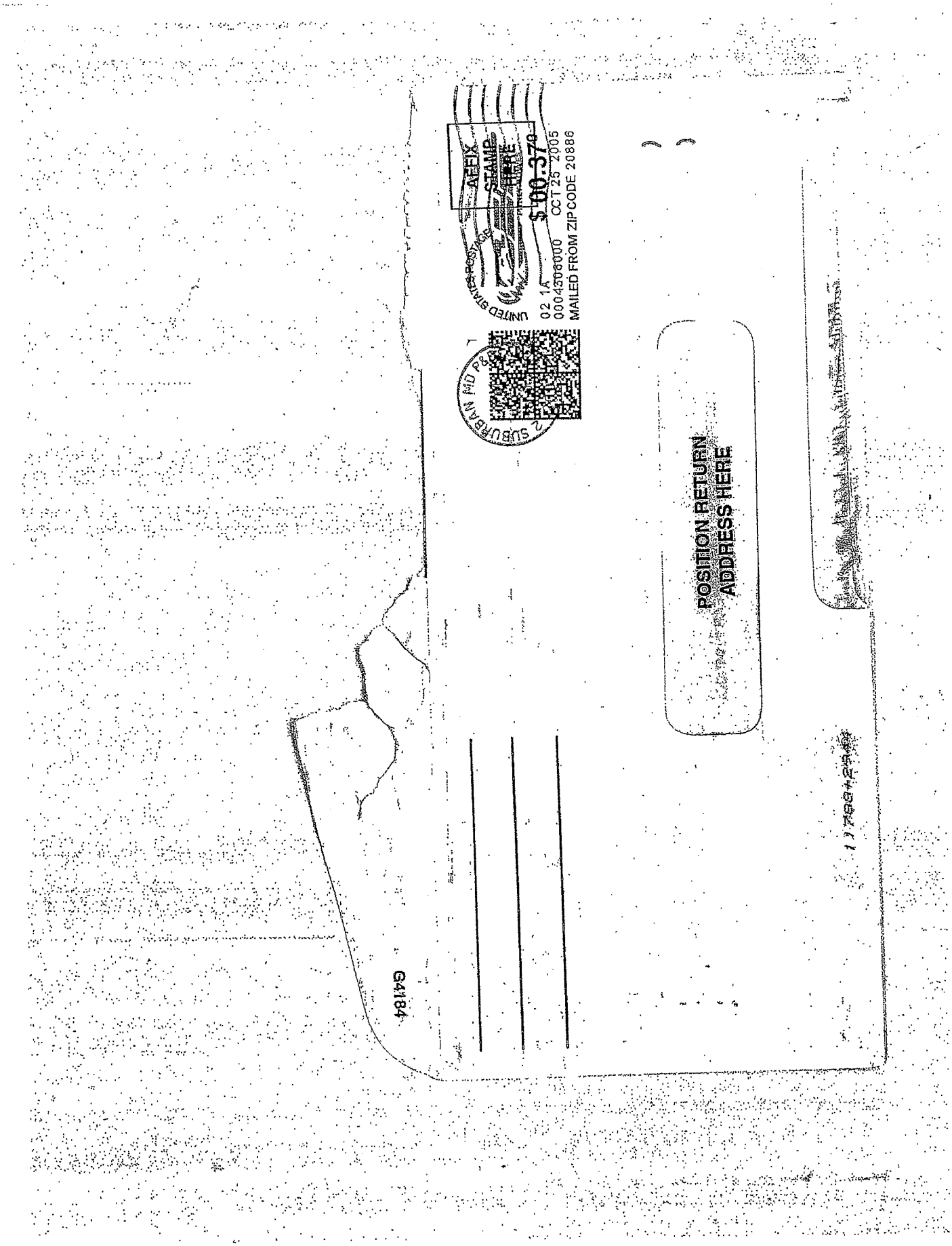
I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073764



CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073765

ALLSTATE
888 VETERANS HWY
SUITE 300
HAUPPAUGE, NY 11788

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER: 212584315 2AW (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE: MM DD YY — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): SAME

CITY

STATE: MD

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY

STATE

ZIP CODE

TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MD

b. EMPLOYER'S NAME OR SCHOOL NAME: CLEANING AUTHORITY

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09/20/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 09 20 2005

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: BRETT GAMMA MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: OTH000

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V22.1
2. 625.9
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 02 2005	09 02 2005	23	4	76815	26	1,2	139.50	1				
2 09 02 2005	09 02 2005	23	4	76817	26	1,2	254.00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 52-1148069 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 500861835

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 393.50

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 393.50

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

BRUCE J BORTNICK MD

SIGNED 10/25/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SHADY GROVE ADV HOSP
9901 MEDICAL CENTER DR
ROCKVILLE, MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (301) 212-4260

SHADY GROVE RADIOLOGICAL
PO BOX 17124
BALTIMORE, MD 21297

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

Restart # (132) Form (PRI) Line (DP)

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CH

Sta [ ]

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073767

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SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and wer personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and Stat funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control numbe The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 1 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the informatic collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 750 Security Boulevard, Baltimore, Maryland 21244-1850.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073768

Adventist HealthCare
Shady Grove Adventist Hospital
9901 Medical Center Drive Rockville, MD 20850
Imaging Department
Phone (301) 279-6065

NAME:
MRN: 0861835
XRAY#: 78-51-34
LOCATION: ERD-S
ACCT: 000026784033
DOB:

REQUESTING PHYSICIAN: BRETT GAMMA, M.D.
ADMITTING PHYSICIAN: BRETT GAMMA,M.D.

ORDER: 2550150 RESULT: 1697307 ADDENDUM: 0

DATE/TIME OF EXAM: 09/20/2005 9:06:06AM

CLINICAL HISTORY: +PREG

N TRANSVAG ULT OB 8476835 76817

CLINICAL HISTORY: Patient is pregnant and presents with pelvic pain. Uncertain of her LMP.

OB SONOGRAM

Both transabdominal and endovaginal examinations were performed. The size of the uterus is 9.6 x 5.5 x 6.8 cm. There is an intrauterine gestational sac with mean diameter of 7.7 mm corresponding to 5 weeks 5 day mensual age. Within the gestational sac there is a well defined 3 mm yolk sac. No fetal pole is identified. No evidence of a subchorionic hemorrhage. There is a 2.3 x 1.4 x 1.8 cm unilocular corpus luteal cyst identified within the right ovary, the overall size of which is 4.2 x 3.8 x 2.9 cm. The left ovary measures 3.5 x 2.1 x 2.1 cm.

IMPRESSION:
1. 5 week 5 day intrauterine gestation with yolk sac identified. No fetal pole at this time.
2. Right corpus luteal cyst measuring 2.3 cm in maximum diameter. Follow up sonogram is recommended in 1-2 weeks.

DICTATED BY: BRUCE BORTNICK, MD
THIS REPORT HAS BEEN ELECTRONICALLY SIGNED.

CEB1 09/20/2005 12:48 Verified

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073769

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073770

PRIMARY CLAIM

LHJ7

PLEASE DO NOT STARLE IN THIS AREA

OCT 13 2005

ALLSTATE
22600 GATEWAY CENTER DR
CLARKSBURG, MD 20871-2004

Reset to: 2125843108

PICA

HEALTH INSURANCE CLAIM FORM

APPROVED OMB-0938-0008

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X

1a. INSURED'S I.D. NUMBER: 2125843132 (FOR PROGRAM IN ITEM 1): MKR

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY | STATE: MD

8. PATIENT STATUS: Single X | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): (631) 940-1522

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO X | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ALLSTATE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 9/20/05

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 640.03
2. 654.43
3. 625.9
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 9 20 05		23	1	99283	1,2,3	190 00	1		X		
2 RECORD ATTACHED											
3											
4											
5											
6											

RECEIVED
OCT 12 2005
ALLSTATE

25. FEDERAL TAX I.D. NUMBER: 522043450 SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 425439

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X | NO

28. TOTAL CHARGE: $ 190 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 190 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

BRETT GAMMA MD
SIGNED 10/06/05

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SHADY GROVE ADVENTIST HSP
9901 MEDICAL CENTER DR
ROCKVILLE MD 20850

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

240 364 2515
MONTGOMERY EMERGENCY PHYS
PO BOX 17564
BALTIMORE MD 21297
PIN# GRP#

PLEASE PRINT OR TYPE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

FORM CMS-1500 (U2)(12-90)
FORM OWCP-1500 FORM RRB-1500

503-ALLS01- 425439

00001

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073772

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSES(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as a name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

NOTICE: *Under penalty of perjury, I declare that I have read the foregoing, that the facts are true, to the best of my knowledge and belief, and that the treatment and services rendered were reasonable and necessary with respect to the bodily injury sustained.*

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

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ALLSTATE (SG) 073773

MEP00006805

RECEIVED
OCT 12 2005
ALLSTATE

39 **Female Urogenital Problems** (5)

TIME SEEN: 750 Am ROOM: R EMS Arrival
PMD - Dr.
Referred by: ☒ self ☐ PMD ☐ Dr.
HISTORIAN: patient spouse paramedics
HX / EXAM LIMITED BY:

HPI chief complaint: pelvic pain vaginal pain dysuria
vaginal bleeding passing tissue vaginal discharge

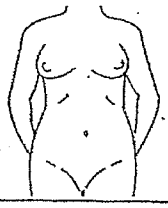
pain at: 0 1 2 3 4 5 6 7 8 9 10

started: 3 Tuk PTA
worse
gone now better
intermittent episodes lasting

severity: mild moderate severe

pregnant
home preg test
HCG in clinic (blood / urine)
WKS / MOS
EDC

pain:
breast pain R / L
pelvic pain
• cramping / pressure / "pain"
burning / sharp
vulvar / vaginal pain
low back pain
flank pain



vaginal bleeding:
abnormal bleeding (started)
compared to menstrual periods: severe / heavier / similar / lighter / spotting
passing clots / tissue

LNMP: Mid July post-menop. s/p hyst.
irregular / missed period(s)
prior abnormal period(s)

urinary symptoms:
blood in urine
frequent urination
discomfort with urination
burning urgency pain

discharge:
vaginal discharge
vag. fluid leakage (pregnant)

Obstetric Hx: G L P A Ab
Sexual Hx: active inactive paid w/ intercourse
Contraceptive: none condom BCP's IUD ☒ tubal

Similar symptoms previously

Recently seen / treated by doctor

Prenatal care: none clinic Dr.
prior sonogram: date IUP fetal demise other

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Shady Grove Adventist Hospital
EMERGENCY PHYSICIAN RECORD

ROS

GI
decreased appetite
nausea
vomiting
diarrhea
black / bloody stools

NEURO
headache

CONST
fever
subjective / ☒
chills

HEENT
eye pain / discharge
sore throat

CVS / PULMONARY
cough
shortness of breath
chest pain

SKIN / LYMPH / MUS
skin rash / swelling
joint pain

☒ all current rx areas marked

PAST HX negative
PID / STD
ectopic pregnancy
ovarian cyst(s)
endometriosis

other problems

Surgeries / Procedures: none
bilat tubal ligation
appendectomy

Medications none see nurses note
ASA NSAID acetaminophen
herbal / alternative medicines

Allergies NKDA
see nurses note

SOCIAL HX smoker ppd
alcohol / drugs / recreational drugs
occupation

FAMILY HX ovarian cysts ovarian cancer

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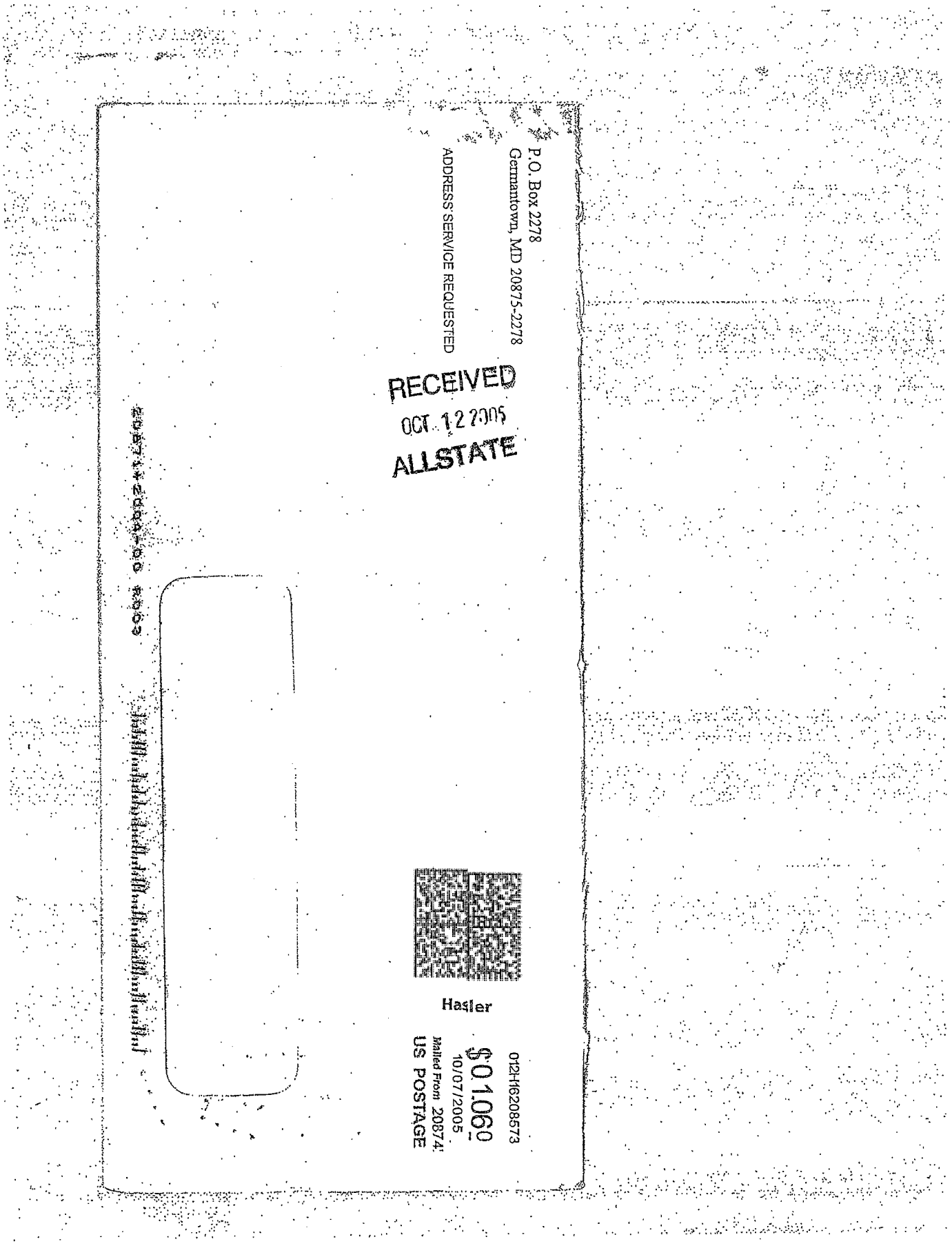

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ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For

Date: 12/01/2005
Bill Received Date: 11/07/2005
Claim # 212584132 01
File Handler: ZAW
Invoice #: 151210R
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE ORTHOPAEDICS
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN
847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/29/05	06/29/05	97110	Therapeutic procedure, o	1.00	$ 43.00	$ 0.00	X999
06/29/05	06/29/05	97140	Manual therapy technique	1.00	$ 43.00	$ 0.00	X999
06/29/05	06/29/05	97140	Manual therapy technique	1.00	$ 43.00	$ 0.00	X999
Total:					$ 129.00	$ 0.00	

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
X999 See Detailed Explanation

Additional Information:
Claim denied for failure to submit written proof of claim to the company.Written proof must be submitted as soon as reasonably practicable, but inno event more than 45 days after the date services are rendered, unlessthe eip, assignee or rep submits proof providing clear & reasonablejustification for failure to comply

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SHADY GROVE ORTHOPAEDICS ASSOC, 9715 MEDICAL CENTER DR #4, ROCKVILLE, MD, 20850

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number, of Insurer or Name and Address of Self-Insurer

ALLSTATE INSURANCE COMPANY
NAIC NUMBER: 008 19232
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

For American Arbitration Association use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON: (Name and Address)
		05/30/05	

E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and Address)	G. AS ASSIGNEE
2125843132 2AW	SHADY GROVE ORTHOPAEDICS ASSOC 9715 MEDICAL CENTER DR #415 ROCKVILLE MD 20850	1. Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

- [ ] 1. Your entire claim is denied as follows:
- [X] 2. A portion of your claim is denied as follows:
  - [ ] A. Loss of Earnings: $
  - [X] B. Health Service Benefits: $ 129.00
  - [ ] C. Other Necessary Expenses: $
  - [ ] D. Interest: $
  - [ ] E. Attorney's Fees: $
  - [ ] F. Death Benefit: $

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

- [ ] 3. Policy not in force on date of accident;
- [ ] 4. Injured person excluded under policy conditions or exclusion;
- [ ] 5. Policy conditions violated.
  - [ ] a. No reasonable justification given for late notice of claim.
  - [ ] b. Reasonable justification not established.
  - You may qualify for expedited arbitration. See page two of this form for instructions.
- [ ] 6. Injured person not an "Eligible Injured Person";
- [ ] 7. Injuries did not arise out of use or operation of a motor vehicle;
- [ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage.

LOSS OF EARNINGS BENEFITS DENIED

- [ ] 9. Period of disability contested; period in dispute From _____ Through _____
- [ ] 10. Claimed loss not proven;
- [ ] 11. Exaggerated earnings claim of $ _____ per month denied
- [ ] 12. Statutory offset taken
- [ ] 13. Other, explained below;

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

- [ ] 14. Amount of claim exceeds daily limit of coverage
- [ ] 15. Unreasonable or unnecessary expenses
- [ ] 16. Incurred after one year from date of accident
- [ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

- [ ] 18. Fees not in accordance with fee schedules
- [ ] 19. Excessive treatment, service, or hospitalization From _____ Through _____
- [ ] 20. Treatment not related to accident
- [ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
- [X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill - treatment dates	28. Date final verification requested	31. Amount paid by insurer
SHADY GROVE ORTHOPAEDICS ASSOC 9715 MEDICAL CENTER DR #415 ROCKVILLE MD 20850	05/29/05 - 05/29/05	NONE REQUESTED	$ 0.00
	26. Date of bill 05/29/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 129.00
24. Type of service rendered	27. Date bill received by insurer 11/07/05	30. Amount of bill $ 129.00	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 12/01/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of Insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

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ALLSTATE (SG) 073778

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/corriphow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

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ALLSTATE (SG) 073779

DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:	ADDRESS	
FAX NUMBER:		
E-MAIL ADDRESS:		
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

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ALLSTATE (SG) 073780

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For

Date: 12/01/2005
Bill Received Date: 11/07/2005
Claim #: 212584313201
File Handler: 2AW
Invoice #: 151210P
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE ORTHOPAEDICS
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN 847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/15/05	06/15/05	99204	Office or other outpatie	1.00	$ 168.00	$ 0.00	X999
06/15/05	06/15/05	72100	Radiologic examination,	1.00	$ 99.00	$ 0.00	X999
Total:					$ 267.00	$ 0.00	

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
X999 See Detailed Explanation

Additional Information:
Claim denied for failure to submit written proof of claim to the company.Written proof must be submitted as soon as reasonably practicable, but inno event more than 45 days after the date services are rendered, unlessthe eip, assignee or rep submits proof providing clear & reasonablejustification for failure to comply

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SHADY GROVE ORTHOPAEDICS ASSOC, 9715 MEDICAL CENTER DR #4, ROCKVILLE, MD, 20850

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer			For American Arbitration Association use
ALLSTATE INSURANCE COMPANY NAIC NUMBER: 008 19232 ISLANDIA 888 VETERANS MEMORIAL HWY; STE 300 HAUPPAUGE NY 11788-			
A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT 05/30/05	D. INJURED PERSON (Name and Address)
E. CLAIM NUMBER 2125843132 2AW	F. APPLICANT FOR BENEFITS (Name and Address) SHADY GROVE ORTHOPAEDICS ASSOC 9715 MEDICAL CENTER DR #415 ROCKVILLE MD 20850		G. AS ASSIGNEE 1. Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

[ ] 1. Your entire claim is denied as follows:

[X] 2. A portion of your claim is denied as follows:

- [ ] A. Loss of Earnings: $
- [X] B. Health Service Benefits: $ 267.00
- [ ] C. Other Necessary Expenses: $
- [ ] D. Interest: $
- [ ] E. Attorney's Fees: $
- [ ] F. Death Benefit: $

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

- [ ] 3. Policy not in force on date of accident
- [ ] 4. Injured person excluded under policy conditions or exclusion:
- [ ] 5. Policy conditions violated
  - [ ] a. No reasonable justification given for late notice of claim.
  - [ ] b. Reasonable justification not established.

  You may qualify for expedited arbitration. See page two of this form for instructions.
- [ ] 6. Injured person not an "Eligible Injured Person"
- [ ] 7. Injuries did not arise out of use or operation of a motor vehicle
- [ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage.

LOSS OF EARNINGS BENEFITS DENIED

- [ ] 9. Period of disability contested; period in dispute From _____ Through _____
- [ ] 10. Claimed loss not proven:
- [ ] 11. Exaggerated earnings claim of $ _____ per month denied
- [ ] 12. Statutory offset taken
- [ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

- [ ] 14. Amount of claim exceeds daily limit of coverage
- [ ] 15. Unreasonable or unnecessary expenses
- [ ] 16. Incurred after one year from date of accident
- [ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

- [ ] 18. Fees not in accordance with fee schedules
- [ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
- [ ] 20. Treatment not related to accident
- [ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
- [X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED.

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill - treatment dates	28. Date final verification requested	31. Amount paid by insurer
SHADY GROVE ORTHOPAEDICS ASSOC 9715 MEDICAL CENTER DR #415 ROCKVILLE MD 20850	06/15/05 - 06/15/05	NONE REQUESTED	$ 0.00
	26. Date of bill 06/15/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 267.00
24. Type of service rendered	27. Date bill received by insurer 11/07/05	30. Amount of bill $ 267.00	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 12/01/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of Insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073782

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complnow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this disput to arbitration or bring a lawsuit, or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073783

DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDULENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO; AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:	ADDRESS	
FAX NUMBER:		
E-MAIL ADDRESS:		
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073784

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

Allstate
You're in good hands.

EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 11/23/2005
Bill Received Date: 11/02/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 151210p
Eligible Injured Person:
Treatment Rendered By: SANDRA F BIRNBAUM PT/SHAD
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN 847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/29/05	06/29/05	97110	Therapeutic procedure, o	1.00	$ 43.00	$ 0.00	X999
06/29/05	06/29/05	97140	Manual therapy technique	2.00	$ 86.00	$ 0.00	X999
Total:					$ 129.00	$ 0.00	

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
X999 See Detailed Explanation

Additional Information:
Claim denied for failure to submit written proof of claim to the company. Written proof must be submitted as soon as reasonably practicable, but in no event more than 45 days after the date services are rendered, unless the eip, assignee or rep submits proof providing clear & reasonable justification for failure to comply with such time limitation.

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618.

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SANDRA F BIRNBAUM PT/SHADY GROVE ORTHO, 9715 MEDICAL CTR D SUITE, ROCKVILLE, MD, 20850

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer			For American Arbitration Association use
ALLSTATE INSURANCE COMPANY NAIC NUMBER: 008 19232 ISLANDIA 888 VETERANS MEMORIAL HWY, STE 300 HAUPPAUGE NY 11788			
A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT 05/30/05	D. INJURED PERSON (Name and Address)
E. CLAIM NUMBER 2125843132 2AW	F. APPLICANT FOR BENEFITS (Name and Address) SANDRA F BIRNBAUM PT/SHADY GROVE ORTHO PT DE 9715 MEDICAL CTR D SUITE 202 ROCKVILLE MD 20850		G. AS ASSIGNEE 1. Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

- [ ] 1. Your entire claim is denied as follows:
- [X] 2. A portion of your claim is denied as follows:
  - [ ] A. Loss of Earnings: $
  - [X] B. Health Service Benefits: $ 129.00
  - [ ] C. Other Necessary Expenses: $
  - [ ] D. Interest: $
  - [ ] E. Attorney's Fees: $
  - [ ] F. Death Benefit: $

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

- [ ] 3. Policy not in force on date of accident:
- [ ] 4. Injured person excluded under policy conditions or exclusion:
- [ ] 5. Policy conditions violated
  - [ ] a. No reasonable justification given for late notice of claim.
  - [ ] b. Reasonable justification not established. **You may qualify for expedited arbitration.** See page two of this form for instructions.
- [ ] 6. Injured person not an "Eligible Injured Person":
- [ ] 7. Injuries did not arise out of use or operation of a motor vehicle
- [ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

- [ ] 9. Period of disability contested: period in dispute From _____ Through _____
- [ ] 10. Claimed loss not proven:
- [ ] 11. Exaggerated earnings claim of $ _____ per month denied
- [ ] 12. Statutory offset taken
- [ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

- [ ] 14. Amount of claim exceeds daily limit of coverage
- [ ] 15. Unreasonable or unnecessary expenses
- [ ] 16. Incurred after one year from date of accident
- [ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

- [ ] 18. Fees not in accordance with fee schedules
- [ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
- [ ] 20. Treatment not related to accident
- [ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
- [X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code) SANDRA F BIRNBAUM PT/SHADY GROVE ORTHO PT DE 9715 MEDICAL CTR D SUITE 202 ROCKVILLE MD 20850	25. Period of bill - treatment dates 06/29/05 - 06/29/05	28. Date final verification requested NONE REQUESTED	31. Amount paid by insurer $ 0.00
	26. Date of bill 06/29/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 129.00
24. Type of service rendered	27. Date bill received by insurer 11/02/05	30. Amount of bill $ 129.00	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 11/23/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of Insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073786

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. You may submit this dispute to arbitration. If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing; listing all bills and proofs as well as a table of contents listing your submissions, must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073787

DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:		
FAX NUMBER:		
E-MAIL ADDRESS:	ADDRESS	
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-4280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073788

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

Allstate
You're in good hands.

EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For

Date: 11/23/2005
Bill Received Date: 10/31/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 151210p
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE ORTHOPAEDICS
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN 847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/15/05	06/15/05	99204	Office or other outpatie	1.00	$ 168.00	$ 0.00	X999
06/15/05	06/15/05	72100	Radiologic examination,	1.00	$ 99.00	$ 0.00	X999
Total:					$ 267.00	$ 0.00	

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
X999 See Detailed Explanation

Additional Information:
Claim denied for failure to submit written proof of claim to the company.Written proof must be submitted as soon as reasonably practicable, but inno event more than 45 days after the date services are rendered, unlessthe eip, assignee or rep submits proof providing clear & reasonablejustification for failure to comply with such time limitation.

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8805 Ext. 7618.

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SHADY GROVE ORTHOPAEDICS ASSOC, 9715 MEDICAL CENTER DR #4, ROCKVILLE, MD, 20850

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer

ALLSTATE INSURANCE COMPANY
NAIC NUMBER: 008 19232
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

For American Arbitration Association use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON (Name and Address)
		05/30/05	

E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and Address)	G. AS ASSIGNEE
2125843132 2AW	SHADY GROVE ORTHOPAEDICS ASSOC 9715 MEDICAL CENTER DR #415 ROCKVILLE MD 20850	1. Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

[ ] 1. Your entire claim is denied as follows:
[X] 2. A portion of your claim is denied as follows:

[ ] A. Loss of Earnings:	$	[ ] D. Interest:	$
[X] B. Health Service Benefits:	$ 267.00	[ ] E. Attorney's Fees:	$
[ ] C. Other Necessary Expenses:	$	[ ] F. Death Benefit:	$

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

[ ] 3. Policy not in force on date of accident:
[ ] 4. Injured person excluded under policy conditions or exclusion:
[ ] 5. Policy conditions violated
[ ] a. No reasonable justification given for late notice of claim.
[ ] b. Reasonable justification not established.
You may qualify for expedited arbitration.
See page two of this form for instructions.
[ ] 6. Injured person not an "Eligible Injured Person":
[ ] 7. Injuries did not arise out of use or operation of a motor vehicle
[ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

[ ] 9. Period of disability contested; period in dispute From _____ Through _____
[ ] 10. Claimed loss not proven:
[ ] 11. Exaggerated earnings claim of $ _____ per month denied
[ ] 12. Statutory offset taken
[ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

[ ] 14. Amount of claim exceeds daily limit of coverage
[ ] 15. Unreasonable or unnecessary expenses
[ ] 16. Incurred after one year from date of accident
[ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

[ ] 18. Fees not in accordance with fee schedules
[ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
[ ] 20. Treatment not related to accident
[ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
[X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code) SHADY GROVE ORTHOPAEDICS ASSOC 9715 MEDICAL CENTER DR #415 ROCKVILLE MD 20850	25. Period of bill - treatment dates 05/15/05 - 06/15/05	28. Date final verification requested NONE REQUESTED	31. Amount paid by insurer $ 0.00
	26. Date of bill 10/25/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 267.00
24. Type of service rendered	27. Date bill received by insurer 10/31/05	30. Amount of bill $ 267.00	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 11/23/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT: 7616

Name and Address of Insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073790

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complnow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this disput to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073791

DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF, AND REASONABLE INQUIRY, THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:		
FAX NUMBER:		
E-MAIL ADDRESS:	ADDRESS	
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

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ALLSTATE (SG) 073792

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

Allstate
You're in good hands.

EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 11/17/2005
Bill Received Date: 10/28/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 500861835
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE RADIOLOGICAL
Provider Specialty:
TIN: 52-1148069

Diagnosis Codes
V22.1 SUPERVISION OF OTHER NORMAL PREGNANCY 625.9 UNSPECIFIED SYMPTOM ASSOCIATED WITH FEM

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
09/20/05	09/20/05	76815-26	Ultrasound, pregnant ute	1.00	$ 139.50	$ 0.00	X201
09/20/05	09/20/05	76817-26	Ultrasound, pregnant ute	1.00	$ 254.00	$ 0.00	X201
Total:					$ 393.50	$ 0.00	

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
X201 This procedure was performed for a condition not related to the motor vehicle accident.

Modifier Code(s):
26 Professional Component

If you have any questions about this claim, please contact your file handler,
DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON DE, 19805-1266

SHADY GROVE RADIOLOGICAL, PO BOX 17124, BALTIMORE, MD, 21297-1124

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer

ALLSTATE INSURANCE COMPANY
NAIC NUMBER: 008 19232
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

For American Arbitration Association use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON (Name and Address)
		05/30/05	

E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and Address)	G. AS ASSIGNEE
2125843132 2AW	SHADY GROVE RADIOLOGICAL PO BOX 17124 BALTIMORE MD 21297-1124	1. Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

[ ] 1. Your entire claim is denied as follows:
[X] 2. A portion of your claim is denied as follows:

[ ] A. Loss of Earnings:	$	[ ] D. Interest:	$
[X] B. Health Service Benefits:	$ 393.50	[ ] E. Attorney's Fees:	$
[ ] C. Other Necessary Expenses:	$	[ ] F. Death Benefit:	$

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

[ ] 3. Policy not in force on date of accident.
[ ] 4. Injured person excluded under policy conditions or exclusion:
[ ] 5. Policy conditions violated
[ ] a. No reasonable justification given for late notice of claim.
[ ] b. Reasonable justification not established.
You may qualify for expedited arbitration.
See page two of this form for instructions.
[ ] 6. Injured person not an "Eligible Injured Person".
[ ] 7. Injuries did not arise out of use or operation of a motor vehicle.
[ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage.

LOSS OF EARNINGS BENEFITS DENIED

[ ] 9. Period of disability contested: period in dispute From _____ Through _____
[ ] 10. Claimed loss not proven:
[ ] 11. Exaggerated earnings claim of $ _____ per month denied
[ ] 12. Statutory offset taken
[ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED:

[ ] 14. Amount of claim exceeds daily limit of coverage
[ ] 15. Unreasonable or unnecessary expenses
[ ] 16. Incurred, after one year from date of accident
[ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

[ ] 18. Fees not in accordance with fee schedules
[ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
[ ] 20. Treatment not related to accident
[ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
[X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill - treatment dates	28. Date final verification requested	31. Amount paid by insurer
SHADY GROVE RADIOLOGICAL PO BOX 17124 BALTIMORE MD 21297-1124	09/20/05 - 09/20/05	NONE REQUESTED	$ 0.00
	26. Date of bill 10/25/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 393.50
24. Type of service rendered	27. Date bill received by insurer 10/28/05	30. Amount of bill $ 393.50	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 11/17/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of Insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073794

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073795

DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY, THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:		
FAX NUMBER:		
E-MAIL ADDRESS:	ADDRESS	
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit; even if you intend to contest this denial.

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(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073796

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY. STE 300
HAUPPAUGE NY 11788

Allstate.
You're in good hands.

EXPLANATION OF MEDICAL BILL PAYMENT

Date: 11/17/2005
Bill Received Date: 10/31/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 500861835
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE RADIOLOGICAL
Provider Specialty:
TIN: 52-1148069

Service Provided For

Diagnosis Codes
V22.1 SUPERVISION OF OTHER NORMAL PREGNANCY. 625.9 UNSPECIFIED SYMPTOM ASSOCIATED WITH FEM

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
09/20/05	09/20/05	76815-26	Ultrasound, pregnant ute	1.00	$ 139.50	$ 0.00	X201
09/20/05	09/20/05	76817-26	Ultrasound, pregnant ute	1.00	$ 254.00	$ 0.00	X201
Total:					$ 393.50	$ 0.00	

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
X201 This procedure was performed for a condition not related to the motor vehicle accident.

Modifier Code(s):
26 Professional Component

If you have any questions about this claim, please contact your file handler,
DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON. 1011 CENTRE RD. STE 210. WILMINGTON. DE. 19805-1266

SHADY GROVE RADIOLOGICAL, PO BOX 17124, BALTIMORE, MD, 21297-1124

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer			For American Arbitration Association use
ALLSTATE INSURANCE COMPANY NAIC NUMBER: 008 19232 ISLANDIA 888 VETERANS MEMORIAL HWY, STE 300 HAUPPAUGE NY 11788			
A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT 05/30/05	D. INJURED PERSON (Name and Address)
E. CLAIM NUMBER 2125843132 2AW	F. APPLICANT FOR BENEFITS (Name and Address) SHADY GROVE RADIOLOGICAL PO BOX 17124 BALTIMORE MD 21297-1124		G. AS ASSIGNEE 1. Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

[ ] 1. Your entire claim is denied as follows:

[X] 2. A portion of your claim is denied as follows:

[ ] A. Loss of Earnings:	$	[ ] D. Interest:	$
[X] B. Health Service Benefits:	$ 393.50	[ ] E. Attorney's Fees:	$
[ ] C. Other Necessary Expenses:	$	[ ] F. Death Benefit	$

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in Item 33)

POLICY ISSUES

[ ] 3. Policy not in force on date of accident;

[ ] 4. Injured person excluded under policy conditions or exclusion;

[ ] 5. Policy conditions violated

[ ] a. No reasonable justification given for late notice of claim.

[ ] b. Reasonable justification not established.
You may qualify for expedited arbitration.
See page two of this form for instructions.

[ ] 6. Injured person not an "Eligible Injured Person";

[ ] 7. Injuries did not arise out of use or operation of a motor vehicle

[ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

[ ] 9. Period of disability contested: period in dispute
From _____ Through _____

[ ] 10. Claimed loss not proven;

[ ] 11. Exaggerated earnings claim of $ _____ per month denied

[ ] 12. Statutory offset taken

[ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

[ ] 14. Amount of claim exceeds daily limit of coverage

[ ] 15. Unreasonable or unnecessary expenses

[ ] 16. Incurred after one year from date of accident

[ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

[ ] 18. Fees not in accordance with fee schedules

[ ] 19. Excessive treatment, service or hospitalization
From _____ Through _____

[ ] 20. Treatment not related to accident

[ ] 21. Unnecessary treatment, service or hospitalization
From _____ Through _____

[X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED.

23. Provider of Health Service (Name, Address and Zip Code) SHADY GROVE RADIOLOGICAL PO BOX 17124 BALTIMORE MD 21297-1124	25. Period of bill - treatment dates 09/20/05 - 09/20/05	28. Date final verification requested NONE REQUESTED	31. Amount paid by insurer $ 0.00
	26. Date of bill 10/26/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 393.50
24. Type of service rendered	27. Date bill received by insurer 10/31/05	30. Amount of bill $ 393.50	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 11/17/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073798

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073799

DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:		
FAX NUMBER:		
E-MAIL ADDRESS:	ADDRESS	
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073800

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

Allstate
You're in Good Hands

EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 10/28/2005
Bill Received Date: 10/04/2005
Claim #: 212584132-01
File Handler: 2AW
Invoice #:
Eligible Injured Person:
Treatment Rendered By: MONTGOMERY EMERGENCY PHYS
Provider Specialty:
TIN: 52-2043450

Diagnosis Codes
847.0 NECK SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
05/31/05	05/31/05	99283	Emergency department vis	1.00	$ 190.00	$ 0.00	4
06/07/05	06/07/05	99283	Emergency department vis	1.00	$ 190.00	$ 0.00	4
Total:					$ 380.00	$ 0.00	

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
4 The CPT/HCPCS procedure code billed is a duplicate of a procedure billed previously.

If you have any questions about this claim, please contact your file handler,
DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

MONTGOMERY EMERGENCY PHYS, PO BOX 17564, BALTIMORE, MD, 21297-1564

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer			For American Arbitration Association use
ALLSTATE INSURANCE COMPANY NAIC NUMBER: 008 19232 ISLANDIA 888 VETERANS MEMORIAL HWY, STE 300 HAUPPAUGE NY 11788			
A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT 05/30/05	D. INJURED PERSON (Name and Address)
E. CLAIM NUMBER 2125843132 2AW	F. APPLICANT FOR BENEFITS (Name and Address) MONTGOMERY EMERGENCY PHYS PO BOX 17564 BALTIMORE MD 21297-1564		G. AS ASSIGNEE 1.Yes [X] 2.No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

- [ ] 1. Your entire claim is denied as follows:
- [X] 2. A portion of your claim is denied as follows:
  - [ ] A. Loss of Earnings: $
  - [X] B. Health Service Benefits: $ 380.00
  - [ ] C. Other Necessary Expenses: $
  - [ ] D. Interest: $
  - [ ] E. Attorney's Fees: $
  - [ ] F. Death Benefit: $

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

- [ ] 3. Policy not in force on date of accident:
- [ ] 4. Injured person excluded under policy conditions or exclusion:
- [ ] 5. Policy conditions violated
  - [ ] a. No reasonable justification given for late notice of claim.
  - [ ] b. Reasonable justification not established.
  - **You may qualify for expedited arbitration.** See page two of this form for instructions.
- [ ] 6. Injured person not an "Eligible Injured Person":
- [ ] 7. Injuries did not arise out of use or operation of a motor vehicle
- [ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

- [ ] 9. Period of disability contested: period in dispute From _____ Through _____
- [ ] 10. Claimed loss not proven:
- [ ] 11. Exaggerated earnings claim of $_____ per month denied
- [ ] 12. Statutory offset taken
- [ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

- [ ] 14. Amount of claim exceeds daily limit of coverage
- [ ] 15. Unreasonable or unnecessary expenses
- [ ] 16. Incurred after one year from date of accident
- [ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

- [ ] 18. Fees not in accordance with fee schedules
- [ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
- [ ] 20. Treatment not related to accident
- [ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
- [X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill - treatment dates	28. Date final verification requested	31. Amount paid by insurer
MONTGOMERY EMERGENCY PHYS PO BOX 17564 BALTIMORE MD 21297-1564	05/31/05 - 06/07/05	NONE REQUESTED	$ 0.00
	26. Date of bill 06/07/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 380.00
24. Type of service rendered	27. Date bill received by insurer 10/04/05	30. Amount of bill $ 380.00	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 10/28/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of Insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073802

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses:

If you choose this option, you may at a later date still submit this disput to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073803

DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION; THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:		
FAX NUMBER:		
E-MAIL ADDRESS:	ADDRESS	
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073804

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

Allstate
You're in good hands.

EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For

Date: 10/28/2005
Bill Received Date: 10/24/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 425439
Eligible Injured Person:
Treatment Rendered By: MONTGOMERY EMERGENCY PHYS
Provider Specialty:
TIN: 52-2043450

Diagnosis Codes
640.03 THREATENED ABORTION, ANTEPARTUM
625.9 UNSPECIFIED SYMPTOM ASSOCIATED WITH FEM
654.43 OTHER ABNORMALITIES IN SHAPE OR POSITIO

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
10/24/05	10/24/05	99283	Emergency department vis	1.00	$ 190.00	$ 0.00	X201
Total:					$ 190.00	$ 0.00	

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
X201 This procedure was performed for a condition not related to the motor vehicle accident.

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON 1011 CENTRE RD STE 210 WILMINGTON DE, 19805-1266

MONTGOMERY EMERGENCY PHYS, PO BOX 17564, BALTIMORE, MD, 21297-1564

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer

ALLSTATE INSURANCE COMPANY
NAIC NUMBER: 008 19232
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

For American Arbitration Association use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON (Name and Address)
		05/30/05	

E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and Address)	G. AS ASSIGNEE
2125843132 2AW	MONTGOMERY EMERGENCY PHYS PO BOX 17564 BALTIMORE MD 21297-1564	1. Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

- [ ] 1. Your entire claim is denied as follows:
- [X] 2. A portion of your claim is denied as follows:
  - [ ] A. Loss of Earnings: $
  - [X] B. Health Service Benefits: $ 190.00
  - [ ] C. Other Necessary Expenses: $
  - [ ] D. Interest $
  - [ ] E. Attorney's Fees: $
  - [ ] F. Death Benefit $

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

- [ ] 3. Policy not in force on date of accident
- [ ] 4. Injured person excluded under policy conditions or exclusion:
- [ ] 5. Policy conditions violated
  - [ ] a. No reasonable justification given for late notice of claim.
  - [ ] b. Reasonable justification not established. **You may qualify for expedited arbitration.** See page two of this form for instructions.
- [ ] 6. Injured person not an "Eligible Injured Person"
- [ ] 7. Injuries did not arise out of use or operation of a motor vehicle
- [ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

- [ ] 9. Period of disability contested: period in dispute From _____ Through _____
- [ ] 10. Claimed loss not proven:
- [ ] 11. Exaggerated earnings claim of $ _____ per month denied
- [ ] 12. Statutory offset taken
- [ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

- [ ] 14. Amount of claim exceeds daily limit of coverage
- [ ] 15. Unreasonable or unnecessary expenses
- [ ] 16. Incurred after one year from date of accident
- [ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

- [ ] 18. Fees not in accordance with fee schedules
- [ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
- [ ] 20. Treatment not related to accident
- [ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
- [X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED.

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill – treatment dates	28. Date final verification requested	31. Amount paid by insurer
MONTGOMERY EMERGENCY PHYS PO BOX 17564 BALTIMORE MD 21297-1564	10/24/05 - 10/24/05	NONE REQUESTED	$ 0.00
	26. Date of bill 09/20/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 190.00
24. Type of service rendered	27. Date bill received by insurer 10/24/05	30. Amount of bill $ 190.00	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 10/28/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7818

Name and Address of Insurer claim processor (Third-Party Administrator), if applicable

Continued on reverse side

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073806

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint, to the Insurance Department at one of the above addresses.

If you choose this option; you may at a later date still submit this disput to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006.

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue; your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073807

DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDULENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:		
FAX NUMBER:		
E-MAIL ADDRESS:	ADDRESS	
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073808

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

Allstate
You're in good hands.

EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For

Date: 10/12/2005
Bill Received Date: 09/20/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 500861835
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE RADIOLOGICAL
Provider Specialty:
TIN: 52-1148069

Diagnosis Codes
V71.4 OBSERVATION FOLLOWING OTHER ACCIDENT 959.09 INJURY OF FACE AND NECK, OTHER AND UNSP

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/07/05	06/07/05	71020-26	Radiologic examination,	1.00	$ 50.50	$ 43.00	X41
06/07/05	06/07/05	72050-26	Radiologic examination,	1.00	$ 82.50	$ 71.00	X41
Total:					$ 133.00	$ 114.00	

Eligible Amount Based on 100% Coverage $ 114.00

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
X41 The amount allowed is based on provider charges within the provider's geographic region.

Modifier Code(s):
26 Professional Component

If you have any questions about this claim, please contact your file handler,
DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 114.00 was made on 10/12/2005 to:
SHADY GROVE RADIOLOGICAL

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SHADY GROVE RADIOLOGICAL, PO BOX 17124, BALTIMORE, MD, 21297-1124

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer			For American Arbitration Association use
ALLSTATE INSURANCE COMPANY NAIC NUMBER: 008 19232 ISLANDIA 888 VETERANS MEMORIAL HWY, STE 300 HAUPPAUGE NY 11788			
A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT 05/30/05	D. INJURED PERSON (Name and Address)
E. CLAIM NUMBER 2125843132 2AW	F. APPLICANT FOR BENEFITS (Name and Address) SHADY GROVE RADIOLOGICAL PO BOX 17124 BALTIMORE MD 21297-1124		G. AS-ASSIGNEE 1.Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

[ ] 1. Your entire claim is denied as follows:

[X] 2. A portion of your claim is denied as follows:

[ ] A. Loss of Earnings:	$	[ ] D. Interest:	$
[X] B. Health Service Benefits:	$ 19.00	[ ] E. Attorney's Fees:	$
[ ] C. Other Necessary Expenses:	$	[ ] F. Death Benefit:	$

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

[ ] 3. Policy not in force on date of accident.
[ ] 4. Injured person excluded under policy conditions or exclusion:
[ ] 5. Policy conditions violated
[ ] a. No reasonable justification given for late notice of claim.
[ ] b. Reasonable justification not established.
You may qualify for expedited arbitration. See page two of this form for instructions.
[ ] 6. Injured person not an "Eligible Injured Person".
[ ] 7. Injuries did not arise out of use or operation of a motor vehicle
[ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

[ ] 9. Period of disability contested: period in dispute From _____ Through _____
[ ] 10. Claimed loss not proven:
[ ] 11. Exaggerated earnings: claim of $ _____ per month denied
[ ] 12. Statutory offset taken
[ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

[ ] 14. Amount of claim exceeds daily limit of coverage
[ ] 15. Unreasonable or unnecessary expenses
[ ] 16. Incurred after one year from date of accident
[ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

[ ] 18. Fees not in accordance with fee schedules
[ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
[ ] 20. Treatment not related to accident
[ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
[X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code) SHADY GROVE RADIOLOGICAL PO BOX 17124 BALTIMORE MD 21297-1124	25. Period of bill - treatment dates 05/07/05 - 05/07/05	28. Date final verification requested NONE REQUESTED	31. Amount paid by insurer $ 114.00
	26. Date of bill 05/07/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 19.00
24. Type of service rendered	27. Date bill received by insurer 09/20/05	30. Amount of bill $ 133.00	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 10/12/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

CONFIDENTIAL
(PERSONAL INFORMATION REDACTED)
ALLSTATE (SG) 073810

DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. You may submit this dispute to arbitration. If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

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DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY
TELEPHONE NUMBER:	
FAX NUMBER:	
E-MAIL ADDRESS:	ADDRESS
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

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ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 08/16/2005
Bill Received Date: 08/01/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 151210p
Eligible Injured Person:
Treatment Rendered By: SANDRA F BIRNBAUM PT/SHAD
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN 847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
07/11/05	07/11/05	97110	Therapeutic procedure, o	1.00	$ 43.00	$ 43.00	
07/11/05	07/11/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
07/11/05	07/11/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
Total:					$ 129.00	$ 129.00	

Eligible Amount Based on 100% Coverage $ 129.00

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 129.00 was made on 08/16/2005 to:
SAN BIRNBAUM PT/SHADY GROVE ORTHO PT DE

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SANDRA F BIRNBAUM PT/SHADY GROVE ORTHO, 9715 MEDICAL CTR D SUITE, ROCKVILLE, MD, 20850

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ISLANDIA
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HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 08/15/2005
Bill Received Date: 07/22/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 151210p
Eligible Injured Person:
Treatment Rendered By: SANDRA F BIRNBAUM PT/SHAD
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN 847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/22/05	06/22/05	97001	Physical therapy evaluat	1.00	$ 135.00	$ 135.00	
06/22/05	06/22/05	97110	Therapeutic procedure, o	1.00	$ 43.00	$ 43.00	
06/22/05	06/22/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
Total:					$ 221.00	$ 221.00	

Eligible Amount Based on 100% Coverage $ 221.00

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 221.00 was made on 08/15/2005 to:
SAN BIRNBAUM PT/SHADY GROVE ORTHO PT DE

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SANDRA F BIRNBAUM PT/SHADY GROVE ORTHO, 9715 MEDICAL CTR D SUITE, ROCKVILLE, MD, 20850

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ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For

Date: 08/15/2005
Bill Received Date: 07/22/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 151210p
Eligible Injured Person:
Treatment Rendered By: SANDRA F BIRNBAUM PT/SHAD
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN
847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/27/05	06/27/05	97110	Therapeutic procedure, o	1.00	$ 43.00	$ 43.00	
06/27/05	06/27/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
06/27/05	06/27/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
07/06/05	07/06/05	97110	Therapeutic procedure, o	1.00	$ 43.00	$ 43.00	
07/06/05	07/06/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
07/06/05	07/06/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
Total:					$ 258.00	$ 258.00	

Eligible Amount Based on 100% Coverage $ 258.00

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 258.00 was made on 08/15/2005 to:
SAN BIRNBAUM PT/SHADY GROVE ORTHO PT DE

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SANDRA F BIRNBAUM PT/SHADY GROVE ORTHO, 9715 MEDICAL CTR D SUITE, ROCKVILLE, MD, 20850

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 08/16/2005
Bill Received Date: 07/29/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 151210p
Eligible Injured Person:
Treatment Rendered By: SANDRA F BIRNBAUM PT/SHAD
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN 847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
07/13/05	07/13/05	97110	Therapeutic procedure, o	1.00	$ 43.00	$ 43.00	
07/13/05	07/13/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
07/13/05	07/13/05	97140	Manual therapy technique	1.00	$ 43.00	$ 43.00	
Total:					$ 129.00	$ 129.00	

Eligible Amount Based on 100% Coverage $ 129.00

Deductible applied to date $ 200.00 from deductible Limit of $ 200.00

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 129.00 was made on 08/16/2005 to:
SAN BIRNBAUM PT/SHADY GROVE ORTHO PT DE

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SANDRA F BIRNBAUM PT/SHADY GROVE ORTHO, 9715 MEDICAL CTR D SUITE, ROCKVILLE, MD, 20850

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 08/16/2005
Bill Received Date: 07/26/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 151210P
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE ORTHOPAEDICS
Provider Specialty:
TIN: 52-1061922

Diagnosis Codes
847.0 NECK SPRAIN 847.2 LUMBAR SPRAIN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/29/05	06/29/05	99213	Office or other outpatie	1.00	$ 100.00	$ 96.00	41
Total:					$ 100.00	$ 96.00	

Eligible Amount Based on 100% Coverage $ 96.00

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Reason Code(s):
41 The amount allowed is based on provider charges within the provider's geographic region.

If you have any questions about this claim, please contact your file handler,
DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 96.00 was made on 08/16/2005 to:
SHADY GROVE ORTHOPAEDICS ASSOC

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD, STE 210, WILMINGTON, DE, 19805-1266

SHADY GROVE ORTHOPAEDICS ASSOC, 9715 MEDICAL CENTER DR #4, ROCKVILLE, MD, 20850

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer			For American Arbitration Association use
ALLSTATE INSURANCE COMPANY NAIC NUMBER: 008 19232 ISLANDIA 888 VETERANS MEMORIAL HWY, STE 300 HAUPPAUGE NY 11788			
A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT 05/30/05	D. INJURED PERSON (Name and Address)
E. CLAIM NUMBER 2125843132 2AW	F. APPLICANT FOR BENEFITS (Name and Address) SHADY GROVE ORTHOPAEDICS ASSOC 9715 MEDICAL CENTER DR #415 ROCKVILLE MD 20850		G. AS ASSIGNEE 1.Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

- [ ] 1. Your entire claim is denied as follows:
- [X] 2. A portion of your claim is denied as follows:
  - [ ] A. Loss of Earnings: $ _____
  - [X] B. Health Service Benefits: $ 4.00
  - [ ] C. Other Necessary Expenses: $ _____
  - [ ] D. Interest: $ _____
  - [ ] E. Attorney's Fees: $ _____
  - [ ] F. Death Benefit: $ _____

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

- [ ] 3. Policy not in force on date of accident
- [ ] 4. Injured person excluded under policy conditions or exclusion:
- [ ] 5. Policy conditions violated
  - [ ] a. No reasonable justification given for late notice of claim.
  - [ ] b. Reasonable justification not established.
  - **You may qualify for expedited arbitration.** See page two of this form for instructions.
- [ ] 6. Injured person not an "Eligible Injured Person":
- [ ] 7. Injuries did not arise out of use or operation of a motor vehicle
- [ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

- [ ] 9. Period of disability contested: period in dispute From _____ Through _____
- [ ] 10. Claimed loss not proven:
- [ ] 11. Exaggerated earnings claim of $ _____ per month denied
- [ ] 12. Statutory offset taken
- [ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

- [ ] 14. Amount of claim exceeds daily limit of coverage
- [ ] 15. Unreasonable or unnecessary expenses
- [ ] 16. Incurred after one year from date of accident
- [ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

- [ ] 18. Fees not in accordance with fee schedules
- [ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
- [ ] 20. Treatment not related to accident
- [ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
- [X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill - treatment dates	28. Date final verification requested	31. Amount paid by insurer
SHADY GROVE ORTHOPAEDICS ASSOC 9715 MEDICAL CENTER DR #415 ROCKVILLE MD 20850	06/29/05 - 06/29/05	NONE REQUESTED	$ 96.00
	26. Date of bill 06/29/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 4.00
24. Type of service rendered	27. Date bill received by insurer 07/26/05	30. Amount of bill $ 100.00	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See attached Explanation of Benefits.

DATED: 08/16/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of Insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

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DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee; payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

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DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

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ARBITRATION REQUESTED BY: LAST NAME FIRST NAME	NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER:		
FAX NUMBER:		
E-MAIL ADDRESS:	ADDRESS	
SIGNATURE	ARE YOU AN ATTORNEY? ☐ YES ☐ NO	DATE

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

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ISLANDIA
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HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 08/09/2005
Bill Received Date: 07/14/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 26306902
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE ADVENTIST HOS
Provider Specialty:
TIN: 52-1532556

Diagnosis Codes
922.31 CONTUSION OF BACK
959.8 OTHER AND UNSPECIFIED INJURY TO OTHER S
847.0 NECK SPRAIN
E812.0 OTHER MOTOR VEHICLE TRAFFIC ACCIDENT IN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/07/05	06/07/05	J0000	Pharmaceutical/prescript	1.00	$ 0.06	$ 0.06	
06/07/05	06/07/05	71020-TC	Radiologic examination,	1.00	$ 77.59	$ 77.59	
06/07/05	06/07/05	72040-TC	Radiologic examination,	1.00	$ 77.59	$ 77.59	
06/07/05	06/07/05	ERSVC	Emergency room service	1.00	$ 115.00	$ 115.00	
06/07/05	06/07/05	93005	Electrocardiogram, routi	1.00	$ 32.03	$ 32.03	
Total:					$ 302.27	$ 302.27	

Eligible Amount Based on 100% Coverage $ 302.27

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

Modifier Code(s):
TC Technical Component

If you have any questions about this claim, please contact your file handler,
DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 302.27 was made on 08/09/2005 to:
SHADY GROVE ADVENTIST HOS

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY, SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SHADY GROVE ADVENTIST HOS, PO BOX 62153, BALTIMORE, MD, 21264-2153

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGENY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 09/07/2005
Bill Received Date: 08/16/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 425439
Eligible Injured Person:
Treatment Rendered By: MONTGOMERY EMERGENCY PHYS
Provider Specialty:
TIN: 52-2043450

Diagnosis Codes
847.0 NECK SPRAIN
922.31 CONTUSION OF BACK
E929.0 LATE EFFECTS OF MOTOR VEHICLE ACCIDENT

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
06/07/05	06/07/05	99283	Emergency department vis	1.00	$ 190.00	$ 190.00	
Total:					$ 190.00	$ 190.00	

Eligible Amount Based on 100% Coverage $ 190.00

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

If you have any questions about this claim, please contact your file handler,
DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 190.00 was made on 09/07/2005 to:
MONTGOMERY EMERGENCY PHYS

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY, SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

MONTGOMERY EMERGENCY PHYS, PO BOX 17564, BALTIMORE, MD, 21297-1564

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HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For

Date: 09/07/2005
Bill Received Date: 08/16/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 425439
Eligible Injured Person:
Treatment Rendered By: MONTGOMERY EMERGENCY PHYS
Provider Specialty:
TIN: 52-2043450

Diagnosis Codes
847.0 NECK SPRAIN
847.2 LUMBAR SPRAIN
E812.0 OTHER MOTOR VEHICLE TRAFFIC ACCIDENT IN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
05/31/05	05/31/05	99283	Emergency department vis	1.00	$ 190.00	$ 190.00	
Total:					$ 190.00	$ 190.00	

Eligible Amount Based on 100% Coverage $ 190.00

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 190.00 was made on 09/07/2005 to:
MONTGOMERY EMERGENCY PHYS

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

MONTGOMERY EMERGENCY PHYS, PO BOX 17564, BALTIMORE, MD, 21297-1564

ALLSTATE INSURANCE COMPANY
ISLANDIA
888 VETERANS MEMORIAL HWY, STE 300
HAUPPAUGE NY 11788

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EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:

Date: 08/09/2005
Bill Received Date: 07/14/2005
Claim #: 2125843132-01
File Handler: 2AW
Invoice #: 26277194
Eligible Injured Person:
Treatment Rendered By: SHADY GROVE ADVENTIST HOS
Provider Specialty:
TIN: 52-1532556

Diagnosis Codes
847.0 NECK SPRAIN
959.09 INJURY OF FACE AND NECK, OTHER AND UNSP
847.2 LUMBAR SPRAIN
E812.0 OTHER MOTOR VEHICLE TRAFFIC ACCIDENT IN

Date Of Service(s) From	Thru	Procedure/Revenue Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
05/31/05	05/31/05	J0000	Pharmaceutical/prescript	1.00	$ 0.10	$ 0.10	
05/31/05	05/31/05	ERSVC	Emergency room service	1.00	$ 231.00	$ 231.00	
Total:					$ 231.10	$ 231.10	

Eligible Amount Based on 100% Coverage	$ 231.10
Less Remaining Policy Deductible	$ 200.00
Covered Amount After Deductible	$ 31.10

Deductible applied to date $ 200.00 from deductible limit of $ 200.00

If you have any questions about this claim, please contact your file handler, DAWN MACIASZEK at (866) 371-8905 Ext. 7618

Payment for $ 31.10 was made on 08/09/2005 to:
SHADY GROVE ADVENTIST HOS

Copy(s) of this Explanation of Benefits has been sent to:
MURPHY SPADARO & LANDON, 1011 CENTRE RD STE 210, WILMINGTON, DE, 19805-1266

SHADY GROVE ADVENTIST HOS, PO BOX 62153, BALTIMORE, MD, 21264-2153

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, Address and NAIC Number of Insurer or Name and Address of Self-Insurer			For American Arbitration Association use
ALLSTATE INSURANCE COMPANY NAIC NUMBER: 008 19232 ISLANDIA 888 VETERANS MEMORIAL HWY, STE 300 HAUPPAUGE NY 11788			
A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT 05/30/05	D. INJURED PERSON (Name and Address)
E. CLAIM NUMBER 2125843132 2AW	F. APPLICANT FOR BENEFITS (Name and Address) SHADY GROVE ADVENTIST HOS PO BOX 62153 BALTIMORE MD 21264-2153		G. AS ASSIGNEE 1.Yes [X] 2. No [ ]

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

[ ] 1. Your entire claim is denied as follows;

[X] 2. A portion of your claim is denied as follows:

[ ] A. Loss of Earnings:	$	[ ] D. Interest:	$
[X] B. Health Service Benefits:	$ 200.00	[ ] E. Attorney's Fees:	$
[ ] C. Other Necessary Expenses:	$	[ ] F. Death Benefit:	$

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

[ ] 3. Policy not in force on date of accident;
[ ] 4. Injured person excluded under policy conditions or exclusion;
[ ] 5. Policy conditions violated
[ ] a. No reasonable justification given for late notice of claim.
[ ] b. Reasonable justification not established.
You may qualify for expedited arbitration.
See page two of this form for instructions.
[ ] 6. Injured person not an "Eligible Injured Person";
[ ] 7. Injuries did not arise out of use or operation of a motor vehicle
[ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

[ ] 9. Period of disability contested; period in dispute From _____ Through _____
[ ] 10. Claimed loss not proven;
[ ] 11. Exaggerated earnings claim of $ _____ per month denied
[ ] 12. Statutory offset taken
[ ] 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

[ ] 14. Amount of claim exceeds daily limit of coverage
[ ] 15. Unreasonable or unnecessary expenses
[ ] 16. Incurred after one year from date of accident
[ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

[ ] 18. Fees not in accordance with fee schedules
[ ] 19. Excessive treatment, service or hospitalization From _____ Through _____
[ ] 20. Treatment not related to accident
[ ] 21. Unnecessary treatment, service or hospitalization From _____ Through _____
[X] 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code) SHADY GROVE ADVENTIST HOS PO BOX 62153 BALTIMORE MD 21264-2153	25. Period of bill - treatment dates 05/31/05 - 05/31/05	28. Date final verification requested NONE REQUESTED	31. Amount paid by insurer $ 31.10
	26. Date of bill 05/31/05	29. Date final verification received NONE REQUESTED	32. Amount in dispute $ 200.00
24. Type of service rendered	27. Date bill received by insurer 07/14/05	30. Amount of bill $ 231.10	

33. State reason for denial, fully and explicitly (attach extra sheets if needed): The policy deductible has been applied to this bill as per attached.

DATED: 08/09/05

DAWN MACIASZEK
Name and Title of Representative of Insurer

TELEPHONE NUMBER: 866-371-8905 EXT. 7618

Name and Address of Insurer claim processor (Third Party Administrator), if applicable

Continued on reverse side

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DENIAL OF CLAIM FORM — PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501 or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at one of the above addresses.

If you choose this option, you may at a later date still submit this disput to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

New York No-Fault Conciliation Center
American Arbitration Association (AAA)
65 Broadway,
New York, New York 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer, at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made:_____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.)

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.)

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

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DENIAL OF CLAIM FORM - PAGE THREE

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN A CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

<table>
<tr><td>ARBITRATION REQUESTED BY:
LAST NAME FIRST NAME</td><td colspan="2">NAME OF LAW FIRM, IF ANY</td></tr>
<tr><td>TELEPHONE NUMBER:</td><td colspan="2" rowspan="3">ADDRESS</td></tr>
<tr><td>FAX NUMBER:</td></tr>
<tr><td>E-MAIL ADDRESS:</td></tr>
<tr><td>SIGNATURE</td><td>ARE YOU AN ATTORNEY?
☐ YES ☐ NO</td><td>DATE</td></tr>
</table>

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit; even if you intend to contest this denial.

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CERTIFICATE OF SERVICE

I, Andrew T. Hahn, Sr., Esq., certify that on the 31st day of May, 2012, a true and correct copy of the foregoing Declaration of Gil Leib in Support of Allstate's Opposition to the Motion for Class Certification was served upon below counsel of record via E Mail and Federal Express:

John S. Spadaro, Esq.
John Sheehan Spadaro, LLC
724 Yorklyn Road, Suite 375
Hockessin, DE 19707
jspadaro@johnsheehanspadaro.com

Dated: New York, New York
May 31, 2012

Andrew T. Hahn, Sr.